DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

MCJA

MAY 2 4 2005

MEMORANDUM FOR RECORD

SUBJECT: Approval of Findings and Recommendations of Functional Assessment Team Concerning Detainee Medical Operations for OEF, GTMO, and OIF

1. I have reviewed the findings and recommendations of the assessment team concerning detainee medical operations for OEF, GTMO, and OIF and the legal review of that report.

2. I hereby approve all the findings and recommendations except the recommendation that psychiatrists/physicians not be used as members of a Behavioral Science Consultation Team (BSCT) and that all detained individuals be treated to the same care standards as U.S. patients in the theater of operation. I direct that these recommendations be further reviewed to determine whether these recommendations should be approved.

3. I also direct the MEDCOM Staff Judge Advocate to make appropriate coordination with the Army Inspector General's Office concerning the alleged misconduct of two senior officers pursuant to paragraph 8-3, AR 20-1.

4. Lastly, I direct that the MEDCOM Staff Judge Advocate coordinate with the appropriate Command/Investigative Organization to determine the final disposition of the other three incidents that were previously referred by the assessment team for appropriate action.

KEVIN C. KILEY, M.D.
Lieutenant General
The Surgeon General

Report Documentation Page

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DEPARTMENT OF THE ARMY
US ARMY MEDICAL RESEARCH AND MATERIEL COMMAND
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FORT DETRICK, MD 21702-5012

REPLY TO
ATTENTION OF

MCMR-ZA

13 April 2005

MEMORANDUM FOR The Army Surgeon General, 5109 Leesburg Pike, Falls Church, VA 22041-3258

SUBJECT: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF

1. Reference Memorandum, TSG, Army, Subject: Appointment as Team Leader, Functional Assessment Team, dated 12 November 2004.

2. The attached report documents the assessment of detainee medical operations for the OEF, GTMO, and OIF completed during the period 23 November 2004 to13 April 2005.

3. The report includes the background and methodology utilized by the Team and addresses each area of interest specified in the appointment memorandum, with findings, discussion and recommendations. The report highlights other key observations pertinent to detainee medical operations, and includes a table of reported incidents and allegations related to medical records, medical practice, interrogation, supplies, staffing, and potential abuse.

4. The team appreciated the courtesies and cooperation provided throughout the visits by all headquarters and staff elements and their personnel, particularly the 30th Medical Brigade and European Regional Medical Command which provided outstanding support for our overseas travels. In traveling to more than 22 states and five foreign countries, an extensive logistical effort was required to arrange interviews and provide work space for the interviews. The team was continually impressed by the dedication and devotion of the Soldiers interviewed. Their commitment to providing quality healthcare for detainees as well as U.S. and Coalition Forces was clearly evident.

5. POC for the attached report is COL (b)(6)-2
(b)(6)-2

LESTER MARTINEZ-LOPEZ
Major General, Medical Corps
Commanding

ENCL

FINAL REPORT

ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO, AND OIF

OFFICE OF THE
SURGEON GENERAL
ARMY

13 April 2005

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ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO, AND OIF

OFFICE OF THE SURGEON GENERAL, ARMY

13 APRIL 2005

EXECUTIVE SUMMARY

On 12 November 2004, The Army Surgeon General, LTG Kevin C. Kiley, directed the Commander of the U.S. Army Medical Research and Materiel Command, MG Lester Martinez-Lopez, to lead a multidisciplinary Functional Assessment Team (the Team) to assess detainee medical operations in Operation Enduring Freedom (OEF), Guantanamo Bay, Cuba (GTMO) and Operation Iraqi Freedom (OIF). LTG Kiley specifically directed the team to look at 14 assessment questions with respect to Army active component (AC) and reserve component (RC) medical personnel providing support and/or care to detainees in Afghanistan, Cuba, and Iraq. In formulating the assessment approach, the team reviewed previous assessments related to detainee operations and investigations of detainee abuse, as well as policies, regulations, and field manuals outlining the precepts of detainee operations. The medical assessment focused on aspects related to: (1) detainee medical policies and procedures, (2) medical records management, and (3) the incidence and reporting of alleged detainee abuse by medical personnel; the fourth focus area of training medical personnel for the detainee health care mission was addressed within focus areas (2) and (3).

The Team found a dedicated and committed cadre of medical personnel whose goal and desire were to provide high quality healthcare for each patient they treated, regardless of status. While medical personnel faced numerous challenges in a stress-filled environment, the interviewees continually described the compassionate and dedicated care they provided to detainees. Many medical personnel described the extraordinary measures and efforts put forth to care for and save the lives of detainees. Our medical Soldiers represent the best our country has to offer and they truly gave of themselves to serve our Nation.

Methods

The Team interviewed medical personnel in maneuver, combat support, and combat service support units in 22 states and 5 countries. The interviewees were preparing to deploy (future), had previously deployed (past), or were currently deployed (present) to OEF, GTMO, or OIF; they included AC and RC (U.S. Army Reserve (USAR) and National Guard (NG)) personnel. For the current interviews, the Team visited the detention medical facilities at Bagram, Afghanistan and Guantanamo Bay, Cuba, and in Iraq, the Team met with the Commander, Task Force (TF) 134 (TF responsible for detainee operations), and interviewed medical personnel supporting detainee operations at Abu Ghraib, Camp Danger, Camp Liberty and Camp Bucca. In Kuwait,

the Team met with the Combined Forces Land Component Command (CFLCC) Deputy Commander and Chief of Staff, as well as the CFLCC Surgeon, to gain a perspective on the planning factors for detainee medical operations. For the past and future interviews, the Team traveled to units in 22 states and Germany. A leadership perspective on the issue of detainee medical operations was gained through interviews with medical personnel from command and control elements at corps, theater, and level I, II and III medical units. For training interviews, the Team visited faculty and students of training programs at the Army Medical Department Center and School (AMEDDC&S), and trainers at the Military Intelligence (MI) School, National Training Center (NTC), Joint Readiness Training Center (JRTC), Continental U.S. Replacement Centers (CRC), and 12 Power Projection Platform (PPP) sites. Additionally, lesson plans and other training materials were reviewed at these training sites.

Units

The identification of each unit, the location in theater, and personnel providing medical support to detainees for OEF and GTMO was more easily discernable than for the OIF theater. In OIF, more than 50,000 detainees have moved from point of capture and collection points, through brigade (Bde) and division internment facilities, to the major prison facilities. Due to the rapidly evolving operational environment, medical personnel served in numerous locales in the OIF theater and provided detainee medical support across the continuum of care, ranging from medical screening to acute trauma management, evacuation, and long-term rehabilitative and chronic disease care.

Interviews

A total of 1,182 personnel were queried, from over 180 military units, in the following categories:

For the past/present/future personnel, 993 interviews (80%AC/8%USAR/12%NG) encompassed 803 (81%) past, 77 (8%) present, and 113 (11%) future deployers to OEF, GTMO or OIF. These interviewees included 705 (71%) males and 288 (29%) females; 522 (52.7%) officers, 3 (0.3%) warrant officers, and 468 (47%) enlisted personnel.

Questionnaires were completed by 166 students at the AMEDDC&S, encompassing 20 91G (Patient Administration Specialist), 74 91W (Health Care Specialist), 17 91WM6 (Health Care Specialist/Licensed Practical Nurse), 15 91X (Mental Health Specialist), and 40 Officer Basic Course (OBC) students.

A total of 12 PPP questionnaires were completed at Ft. Benning (1 MOB, 1 CRC), Ft. Bliss (1 MOB, 1 CRC), Ft. Carson (1 MOB), Ft. Dix (1 MOB), Ft. Drum (1 MOB), Ft. Hood (1 MOB), Ft. Lewis (1 MOB), Ft. Polk (1 MOB), Ft. Riley (1 MOB), and Ft. Sill (1 MOB). Interviews were conducted at the JRTC (Ft. Polk) and NTC (Ft. Irwin).

Interviews were conducted with 11 past (6) and present (5) Behavioral Science Consultation Team (BSCT) members assigned to GTMO (7) and OIF (4).

Policy and Guidance

Theater-Level Policy and Guidance. In reviewing policy and guidance, including Operation Orders (OPORDERs), Fragmentary Orders (FRAGOs), and Standing Operating Procedures (SOPs), OEF theater-specific detainee medical policies were found dating back to 2004; 47% of past and 60% of present OEF interviewees were aware of the policies. GTMO had well-defined detainee medical policies that have been in place since 2003; 100% of the interviewed personnel were aware of the policies. For OIF, there was no evidence of specific theater-level policies for detainee medical operations until 2004. Only 56% of past OIF interviewees were aware of policies in theater, whereas 88% of current OIF interviewees were aware of policies in theater. This improvement is attributed to the superlative efforts of TF134, combined with the introduction of one field hospital for level III+ detainee health care management across the theater.

Standard of Care. In the early stage of OIF, there was confusion among some medical personnel, both leaders and subordinates, regarding the required standard of care for detainees. Medical personnel were unsure if the standard of care for detainees was the same as that for U.S./Coalition Forces in theater, or if it was the standard of care available in the Iraqi health care system. This confusion may be explained by the use of different classifications for detained personnel (Enemy Prisoner of War (EPW), detainees, Retained Personnel (RP), Civilian Internees (CI)) that, under Department of Defense (DoD) and Department of the Army (DA) guidance, receive different levels care. Theater-level guidance was not provided in a timely manner to early-deploying medical units or personnel, and in the absence of guidance many units developed their own policies. As the OIF theater matured and roles and responsibilities were clarified, theater-level policy was developed and promulgated, resolving the early confusion.

Recommendations. Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency.

Medical Records

Medical Records Training. Medical records management was a primary area of focus for this assessment. When asking past/present/future personnel from OEF, GTMO, and OIF about their training in detainee medical records management, 4% of AC and 6% of RC interviewees received Military Occupational Specialty (MOS) or other school training. When asked about unit training at home station, 6% of AC and 4% of RC interviewees reported receiving training. During mobilization, 5% of AC and 8% of RC interviewees reported receiving training about detainee medical records. For

past/present personnel from OEF, GTMO, and OIF, 27% of AC and 35% of RC interviewees reported receiving training in theater.

Medical Records Generation. There was wide variability in medical records generation at level I and II facilities. In some cases, no records were generated. In others, detainee care was documented in a log book for statistical purposes and unit reports. In other cases, care was documented on Field Medical Cards (FMCs) (Department of Defense Form 1380 (DD1380)) only. Some of the units with log books or FMCs created Standard Form 600 (SF600) (Chronological Record of Medical Care) for detainee patients requiring complex treatment, with chronic medical conditions, and/or for those being evacuated to higher levels of care. Some units used overprinted SF600 to document screenings, and others used completed SF88 (Report of Medical Examination) and SF93 (Report of Medical History). Level III facilities consistently generated detainee medical records in the same manner as records for U.S. and Coalition Forces.

Access to and Security of Detainee Medical Records at Detention Medical Facilities. The Team was asked to address access to, and security of, detainee medical records at detention medical facilities. This was accomplished with several specific interview questions as well as direct observations and questions during site visits to the facilities at OEF, GTMO, and OIF. Individual responses to the pertinent questions were generally very consistent within each location, as well as across all locations. In general, the medical records for detainees were managed the same as records for the AC. The security of records and confidentiality of medical information tended to be better at detention facilities that were co-located with medical facilities. Security and confidentiality also generally improved as an individual theater matured. When asked about which "other" personnel could have access to detainee medical records besides the treating medical personnel, the vast majority of answers were: Patient Administration (PAD), Criminal Investigation Division (CID), the International Committee of the Red Cross (ICRC), and medical chain of command. Very few individuals responded that military police (MP) or other detention facility personnel could have access to medical records.

Medical Screening, Medical Care, and Medical Documentation Associated with Interrogation. There are inconsistencies in the guidance for pre- and post-interrogation screening. Medical care, including screenings, at or near the time of interrogation, was neither consistently documented nor consistently included in detainee medical records. Some medical personnel were unclear whether interrogations could be continued if a detainee required medical care during the interrogation. Medical personnel at some locations felt empowered to halt interrogations for either medical or safety reasons.

Storage of Originals and Copies of Medical Records. The team found that level I and II facilities stored original medical records at detention facilities, detention medical facilities, and medical unit treatment areas. In some cases the records were maintained with interrogation records maintained by MI or MP personnel. At level III facilities, the originals were maintained by PAD. The availability of copy machines was variable;

therefore, when detainees were transferred to other detention facilities or medical facilities, either the original or a copy of the medical record was sent.

Disposition of Medical Records. The original detainee medical records and original U.S. Forces medical records at level III facilities are sent to Patient Administration Systems and Biostatistics Activity (PASBA). Within and among all interviewed units providing level I and II medical care, there was extreme variability in the method of documentation, the circumstances influencing the creation of documentation, and the maintenance and final disposition of detainee medical records.

Recommendations. DA guidance (DoD level is preferable) should require that detainee medical records at facilities delivering level III and higher care be generated in the same manner as records of U.S. patients in theater. Guidance should address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care. Most importantly, guidance is needed to define the appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

Reporting of Detainee Abuse

Abuse Reporting Training. The Team found that 16% of AC and 15% of RC interviewees (past/present/future OEF/GTMO/OIF combined) received MOS or other school training about reporting possible detainee abuse. When asked about training at home station on this topic, 21% of AC and 14% of RC interviewees reported receiving training. During mobilization, 25% of AC and 26% of RC interviewees reported receiving training. For the past/present OEF/GTMO/OIF deployers, 40% of AC and 26% RC interviewees reported receiving this training in theater.

Abuse Reporting Policies. Unit policies, SOPs and Tactics, Techniques, and Procedures (TTPs) were most often either absent or not properly disseminated to deployed medical personnel. The Team found no DoD, Army, or theater policies requiring that actual or suspected abuse be documented in a detainee's medical records; however, theater-level guidance specifically requiring medical personnel to report detainee abuse was implemented just within the past year. The Team found that 37.0% (295 of 798) of formerly deployed OEF/GTMO/OIF interviewees were aware of a unit requirement to report suspected detainee abuse; 94.2% (278 of 295) of these interviewees reported their unit followed the policies; 85.5% (65 of 76) of presently deployed OEF/GTMO/OIF interviewees were aware of such policies; and 98.5% (64 of 65) of these interviewees reported their unit followed the policies. Medical personnel with knowledge of existing unit policies/SOPs/TTPs overwhelmingly complied with such guidance (94%) and, over time, awareness of unit level policies requiring reports of detainee abuse has steadily increased.

Observing and Reporting Suspected Detainee Abuse. The personnel interviewed during this assessment were vigilant in reporting actual or suspected detainee abuse to their medical supervisor, chain of command, or CID. Only 5% of previously deployed

interviewees directly observed suspected abuse and only 5% had a detainee report abuse to them. Previously deployed interviewees reported the suspected abuse 91% of the time when the suspected abuse was alleged by a detainee and 80% if they directly observed suspected detainee abuse. For those interviewees presently deployed, 25% had a detainee report alleged abuse and 3% directly observed suspected abuse. All presently deployed interviewees reported the alleged or suspected abuse. Only 2 medical personnel failed to properly report actual or suspected detainee abuse that had not previously been conveyed to an appropriate authority. The Team referred these cases to the CID.

Recommendations.

Medical. At all levels of professional training, medical personnel should receive instruction on the requirement to detect, document and report actual or suspected detainee abuse. This training should include the definition and signs of suspected detainee abuse. Scenario-based training on detecting detainee abuse should be developed and fielded at non-Army Medical Department (AMEDD) training sites such as JRTC, NTC, PPP, CRC, etc. All deploying medical personnel should receive this training prior to arrival in theater.

DoD-Wide. It is important to have clearly written standardized policies for detecting, documenting and reporting actual or suspected detainee abuse at all levels of command. Medical planners at all levels should ensure clearly written standardized guidance is provided to all medical personnel. This guidance should list possible indicators of abuse and contain concise instruction documentation and procedure for reporting actual or suspected abuse.

Other Issues

This assessment addressed several other issues the Team deemed relevant to detainee medical operations that were not specifically directed by the appointing memorandum. The topics include: (1) overview from site visits to Afghanistan, Cuba and Iraq; (2) OIF theater preparation for detainee care; (3) medical screening and sick call at the division internment facilities (DIFs) and prisons; (4) restraints and security; (5) medical personnel interactions with interrogators; (6) medical personnel photographing detainees; (7) the use of behavioral science consultation teams(BSCT) in the interrogation process; (8) stress on medical personnel providing detainee medical care; and (9) interviewee training requests.

Overview of Site Visits to Afghanistan, Cuba and Iraq. The overall quality of outpatient and inpatient detainee medical care is extremely high. Detainees are treated with dignity and respect. Detainee rights and patient rights are clearly posted. Medical records are very complete and contain master problem lists. Daily sick call is well organized. Medical personnel know procedures for reporting abuse and follow those procedures. All facilities are staffed with extremely dedicated personnel who take their responsibilities very seriously.

OIF Theater Preparation for Detainee Care. In planning for detainee medical operations, there were limited assets allocated to provide support for detainee/EPW medical care. The plan did not encompass medical assets to provide chronic care, definitive care, or rehabilitative care. There was a requirement to deliver medical care to detainees in theater; however, level I, II, and III medical assets were not resourced to care for the special needs presented by this population. Recommend the AMEDD establish an experienced subject matter expert (SME) team to comprehensively define the personnel, equipment, and supply needs to support detainee medical operations, and develop a method to ensure a flexible delivery system for these special resources.

Medical Screening and Sick Call at the Division Internment Facilities (DIF) and Prisons. The Team found that detainees have excellent access to daily sick call, outpatient, and inpatient medical care at the DIFs and Prisons. The vast majority of interviewees reported that initial screening medical examinations were performed during in-processing to a DIF or prison. Recommend DA guidance (DoD level is preferable) require initial medical screening examinations shortly after arriving at the detention facility.

Restraints/Security. The use of physical restraints for detainees varied widely within and among all interviewed units. The Team found no evidence that medical personnel used medications to restrain detainees. Interviewees reported medical personnel were tasked to perform a variety of detainee security roles. Medical documentation of restraint was neither uniform nor consistent. Some medical units used restraints on all detainees for security reasons, some used them only when detainees were violent or disruptive, and others (specifically level III facilities) used them only for medical indications such as attempts to dislodge medical devices, or for risk of falling. Interviewees expressed concern over the tasking of medical personnel for detainee security purposes. This concern is based on the ethical conflict of both caring for and guarding detainees. Additionally, as medical personnel were tasked to provide security support, it impacted on the ability of the medical unit to provide care to all patients, including U.S. Soldiers. Recommend DA (DoD level is preferable) standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraints. Medical personnel should not be encumbered with duties related to security of detainees.

Medical Personnel Interactions with Interrogators. The Team found that medical personnel participation in interrogations was exceedingly rare and was reported only five times, and occurred only in OIF at units providing level I or II care. The evaluation or treatment of detainee patients was rarely delayed for intelligence gathering purposes. Medical personnel were rarely requested to be present during interrogations. Many interviewees reported the existence of policies that addressed the interaction between medical personnel and interrogators; however, dissemination and awareness of these policies were inconsistent. As the OEF and OIF theaters matured, dissemination and awareness of these policies improved for level III facilities. DA guidance (DoD level is preferable) should prohibit all medical personnel from active participation in

interrogations. This includes medical personnel with specialized language skills serving as translators. Empower medical personnel to halt interrogations when a necessary examination or treatment is required.

Medical Personnel Photographing Detainees. There are inconsistencies among Army Regulations, individual unit guidance, and usual medical practices regarding photographing detainees. Many medical personnel photographed detainees for a variety of reasons including medical documentation, future teaching material, supporting criminal investigation, and to provide a means for family members to identify a detainee. While AR 190-8, paragraph 1-*5d*, strictly prohibits photographing enemy prisoners of war, retained persons, and civilian internees "for other than internal internment facility administration or intelligence/counterintelligence purposes," chapter 34 of the 2004 edition of the text "Emergency War Surgery" advocates units having a digital or other high quality camera for use in medical documentation of EPW injuries. This text also advocates the inclusion of faces in these pictures for accurate, efficient, and complete documentation of patient injuries and surgical interventions. Additionally, AR 40-66, paragraph 2-8b (which is not specific to detainees), permits photographs but requires consent be obtained prior to releasing photographs "of a person or of any exterior portion of his or her body" for the purpose of research. DA guidance (DoD level is preferable) should authorize photographing detainee patients for the exclusive purpose of including these photos in medical records. Informed consent should not be required to use photographs in this manner (consistent with AR 40-66). Additionally, photographs of detainees taken by medical personnel for other reasons, including future educational material, research, or unit logs, should require a detainee's informed consent.

Behavioral Science Consultation Teams (BSCT). BSCTs consisted of physicians/ psychiatrists and psychologists who directly support detainee interrogation activities. Physicians and psychologists were initially assigned to this duty in 2002 at GTMO and in December 2003 for OIF. Since January 2004 these positions have been staffed by psychologists. This issue has been raised in previous assessments and investigations. There is no doctrine or policy that defines the role of behavioral science personnel in support of interrogation activities. The most complete guidance found by the Team were SOPs that describe the role and responsibilities of personnel serving in BSCT positions. In the purest sense, the mission of the BSCT is to provide forensic psychological expertise and consultation to assist the command in conducting safe, legal, ethical, and effective interrogation and detainee operations. DoD should develop well-defined doctrine and policy for the use of BSCT personnel. A training program for BSCT personnel should be implemented to address the specific duties. The Team recommends that more senior psychologists should serve in this type of position. There is no requirement or need for physicians/psychiatrists to function in this capacity.

Stress on Medical Personnel Providing Detainee Medical Care. Medical personnel were not specifically asked to describe their personal deployment experiences; however, during numerous interviews memories of personal experiences re-surfaced. Many of these interviewees noted this was the first time they had the opportunity to

share personal experiences. The issues raised by medical personnel included the ethical dilemma of providing care to insurgents that killed or injured U.S. Soldiers, providing care to Soldiers and Iraqis with limited medical resources, the quantity and severity of the injuries observed, and the stress of a warfare environment. Recommend the U.S. Army Medical Command (MEDCOM) establish an experienced SME team comprised of a psychiatrist, a psychologist, chaplain, and clinical representation from all levels of care, to comprehensively define the training requirements for medical personnel in their pre-deployment preparation. Other initiatives include revising combat stress control doctrine to effectively deliver support to medical personnel in theater, develop an effective system to regularly monitor post deployment stress, and refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

Interviewee Training Requests. The Team asked interviewees the following question: "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care?" Many interviewees noted that current training in this area was not sufficient. The most commonly recommended topics were: cultural awareness training (including religious differences, local customs, accepted societal behaviors, diet, etc.); basic medical and conversational language training for the respective area of operation, with emphasis on triaging and treating detainee patients and U.S./Coalition patients in the same manner; and medical Rules of Care. Other key training needs identified by the interviewees were stress management for medical personnel; retraining for sub-specialists utilized in other roles (e.g., primary care, emergency room, or general surgery); how to handle interactions with other government agencies (OGAs), MI personnel, and interpreters; field sanitation issues; preparation for long-term care of detainees; treatment of blast and gunshot injuries; and interest in having more mass casualty (MASCAL) exercises.

Conclusion

The Team was very impressed with current detainee medical operations in OEF, GTMO, and OIF. In the early phases there were definite shortcomings; however, in the ongoing maturing process, policies are being established, training conducted, and resources provided to ensure appropriate standardized detainee medical operations. Indeed, a number of interviewees discussed shortcomings at their arrival, but reported significant improvements during their tour. There are still opportunities for improvement and the Team has provided a comprehensive list of recommendations to assist the process. We have been honored to conduct this assessment; the experience has reinforced our pride as members of the AMEDD.

Chapter 2
Background

2-1. Synopsis

a. With the current hostilities in Afghanistan (OEF) and Iraq (OIF), and the confinement by U.S. military personnel of detainees in Afghanistan (GTMO) and Iraq, concerns regarding the appropriate treatment of detainees, including during interrogation and access to medical care, have arisen. Increased concern arose with revelations of detainee abuse in the Abu Ghraib Detention Facility in Iraq. Additionally, reports in the press have alleged wrongdoing by military medical personnel.

b. A series of investigations have alleged wrongdoings and have recommended reforms, including actions of Army medical personnel. Some of these reports looked at medical issues; however, to date, there has not been a medical specific assessment of detainee operations in OEF, GTMO or OIF.

c. The Army Surgeon General (TSG), LTG Kevin C. Kiley, reviewed the Fay/Jones report (Cit. 25) with the Army's senior leadership, including recommendations that further inquiry was necessary to determine (i) if detainee medical records were properly maintained; and (ii) if medical personnel were aware of detainee abuse and failed to report the abuse.

d. On 12 November 2004, LTG Kiley directed MG Lester Martinez-Lopez, Commander of the U.S. Army Medical Research and Materiel Command, to lead a Functional Assessment Team (the Team) to determine whether detainee medical records were properly maintained; whether medical personnel were aware of detainee abuse and failed to report abuse; and to determine whether medical personnel received and/or are currently receiving appropriate training so that they are fully prepared to perform the mission of caring for detainees.

2-2. Chronology of Important Events

Date	Event
7 Oct 01	OEF begins in Afghanistan
11 Nov 01	First detainees secured at Mazar-e-Sharrif
Dec 01	Bagram Holding Area (BHA) and Kandahar Holding Area (KHA) open
Jan 02	ICRC conducts first visit to Bagram detention facility
1 Jan 02	First detainees arrive at GTMO
Jan 02	ICRC conducts first visit to GTMO detention facility
19 Mar 03	Invasion of Iraq begins (OIF)
4 Aug 03	Abu Ghraib prison reopened by the Coalition Provisional Authority (CPA)

Aug 03	MG Miller leads survey team to assess intelligence, interrogation, and detention operations in Iraq (*Miller Report*)
24 Oct 03	Date stamp on prison scandal pictures from Abu Ghraib
Oct / Nov 03	MG Ryder: Office of the Provost Marshal General of the Army – "Report on Detention and Corrections Operations in Iraq" (*Ryder Report*)
Oct 03	ICRC visits Abu Ghraib
Nov 03 – Mar 04	MG Taguba: "AR 15-6 Investigation of the 800th Military Police Brigade" (*Taguba Report*)
Feb 04	ICRC: "Treatment by Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Conventions in Iraq during Internment and Interrogation" submitted to to LTG Sanchez
Feb 04	The Department of the Army Inspector General (DAIG): "Inspection of Detainee Operations Inspections" in OEF, GTMO, and OIF (*DAIG Report*)
Feb 04	Task Force (TF) Oasis begins medical care at Abu Ghraib
Mar 04	MG Fay and LTG Jones: "AR 15-6 investigation of Abu Ghraib Prison and the 205th Military Intelligence Brigade" (*Fay/Jones Report* [also called the *Kern Report*])
May 04	MG Jacoby: "Detention Operations and Facilities in Afghanistan" (*Jacoby Report*)
May 04	Vice Admiral Church investigates DoD interrogation operations in OEF, GTMO and OIF (*Church Report*)
Aug 04	Schlesinger: "Final Report of the Independent Panel to Review DoD Detention Facilities" (*Schlesinger Report*)
Aug 04	115th Field Hospital (FH) arrives at Abu Ghraib
Oct 04	115th FH arrives at Camp Bucca
12 Nov 04	Tasking of the Team

2-3. Previous Reports - Summary of Findings and Recommendations Regarding Detainee Medical Care

a. *Ryder Report* (Cit. 39). The Ryder Report contains several observations regarding detainee medical care, health management and medical care.

(1) No clear delineation of the responsibilities of health care existed for the various detainee categories. This resulted in confusion regarding the responsibilities between the U.S. military and CPA health care systems. MG Ryder stated a clear need for published guidance regarding detainee categorization and health care directives.

(2) The expansion of mission responsibilities, to include serving as the Iraqi correctional medical system until it is fully operational, challenged the health care delivery system.

(3) The rapid turnover of MP Bde Surgeons, on a 90-day rotation, creates significant correctional health care management concerns and inefficiencies. Recommended a one-year rotation for Bde Surgeons who are versant in preventive medicine and/or correctional medical operations for continuity and mission oversight.

(4) Mentally ill detainees were receiving no treatment. Mental illness was a grossly neglected area for the health care of Iraqi detainees. Mental health services must be incorporated into the correctional health care model.

b. *Taguba Report* (Cit. 44). The Taguba report contains minimal comments regarding medical care and medical assets at Abu Ghraib. Two medics provided witness statements. Additionally, testimony from non-medical personnel and detainees included both positive and negative comments concerning medical personnel at Abu Ghraib.

c. *DAIG Report* (Cit. 19). This inspection was a comprehensive review of how the Army conducts detainee operations in Afghanistan and Iraq. Medical issues related to detainee care were included in this functional analysis.

(1) Holding detainees for longer timeframes at all locations resulted in increased requirements in facility infrastructure, medical care, preventive medicine, trained personnel, logistics, and security. Organic unit personnel at these locations did not have the required institutional training and were therefore unaware of, or unable to fully comply with, Army policies in areas such as detainee processing, confinement operations, security, preventive medicine, and interrogation.

(2) The DAIG Team inspected four Internment/Resettlement facilities and 12 forward and central collection points. No units fully complied with the Geneva Conventions requirements for medical treatment of detainees, or with the required sanitary conditions for detainee facilities. Not all medical personnel were aware of detainee medical treatment requirements. They also lacked the proper equipment to treat a detainee population. Medical personnel reported no specific training in detainee operations. There was a widespread lack of preventive medicine resources.

d. *Fay/Jones Report* (Cit. 25). This report did not focus on issues of medical care. The report contains references to, and statements by, medical personnel regarding suspicion of, knowledge of, and reporting of detainee abuse. The report also concludes medically related joint doctrine and policy was not always followed.

(1) Specifically, joint doctrine and policy defines a requirement for medical screening of all detainees. This requirement was not being met at Abu Ghraib. Additionally, there was an absence of medical documentation for some detainees, and a general absence of a centralized management system for medical evaluations. The report also concludes that medical personnel are included in the 54 personnel found to have some degree of responsibility or complicity in the abuse that occurred at Abu Ghraib.

(2) This report recommends improved training to all personnel in Geneva Conventions, detainee operations, and the responsibilities of reporting detainee abuse. The report recommends Training and Doctrine Command (TRADOC) address medical record keeping and information sharing requirements.

e. *Church Report* (Cit. 15). Specific medically related findings include:

(1) Medical personnel understood their responsibility to provide humane medical care to detainees in accordance with U.S. military medical doctrine and the Geneva Conventions.

(2) There was inconsistent field level implementation of medical documentation, medical record handling, and medical treatment (for example, medical screenings).

(3) The report described the role of behavioral science personnel who assisted interrogation personnel to include observing interrogation, assessing detainee behavior and motivations, reviewing interrogation techniques, and offering advice to interrogators. Behavioral science personnel were not involved in detainee medical care, nor did they have access to detainee medical records. This report recommended a DoD level policy review to ensure behavioral science teams performed with proper safeguards. The report also recommended the status of medical personnel who do not participate in patient care be clarified.

(4) DoD level policy review was necessary to define intelligence personnel access to detainee medical information. There was a substantial variation in access to medical information in different locations. However, no misuse of this information was identified.

(5) Admiral Church concluded there was no way to know if medical personnel reported abuse as necessary. Medical personnel stated they reported abuses when it was suspected. The report states that it appeared that medical personnel may have attempted to misrepresent the circumstances of three separate detainee deaths, possibly in an effort to disguise detainee abuse.

f. *Schlesinger Report* (Cit. 40). This report contains only one specific medically related recommendation (which originated with the Fay/Jones). At least three of the 14 recommendations are applicable to all medical leadership and personnel engaged in detention operations. The three recommendations are:

(1) The nation needs more specialists for detention/interrogation operations, including linguists, interrogators, human intelligence (HUMINT), counter-intelligence, corrections police and behavioral scientists.

(2) All personnel engaged in detention operations from the point of capture to final disposition, should participate in a professional ethics program that would serve as the moral compass for guidance in situations with conflicting moral obligations.

(3) Several recommendations from the Fay investigation cited the failure of medical personnel to report detainee abuse, shortfalls in training and force structure for field sanitation, preventive medicine and medical treatment requirements for detainees.

g. The Team reviewed two reports that are presently classified - the *Miller Report* and the *Jacoby Report* (Cit. 29).

Chapter 3
Methodology

3-1. Team Members. In a memo dated 12 November 2004, TSG, LTG Kevin C. Kiley, directed the Team to specifically assess issues related to detainee medical care in the OEF, GTMO, and OIF (Exhibit A, Annex 1). MG Lester Martinez-Lopez, Commanding General, U.S. Army Medical Research and Materiel Command and Fort Detrick, Fort Detrick, MD, led the multi-disciplinary team, which included (see Exhibit B for Team biosketches):

a. COL (b)(6)-2 MS, Garrison Commander, (b)(6)-2 (b)(6)-2

b. COL (b)(6)-2 MC, Staff Internist and Intensivist, (b)(6)-2 (b)(6)-2 Internal Medicine Consultant to TSG, (b)(6)-2

c. COL (b)(6)-2 AN, Deputy Commander for Health Services, (b)(6)-2 (b)(6)-2

d. LTC (b)(6)-2 JA, Staff Judge Advocate, (b)(6)-2 (b)(6)-2

e. MAJ (b)(6)-2 MC, Program Director, Internal Medicine Residency Program, (b)(6)-2

f. MSG (b)(6)-2 91W, Soldier Medic Training Site, Noncommissioned Officer in Charge (NCOIC), (b)(6)-2

3-2. Assessment Questions. The appointment memo specifically directed the Team to assess the following with respect to AC and RC Army medical personnel providing medical support and care to detainees in OEF, GTMO and OIF:

a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?

b. At what location did each unit provide medical care (e.g., Medical Treatment Facility (MTF), detainee facility, and interrogation facility)?

c. What Military Occupational Specialty (MOS) and Officer Basic Training (OBC) training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?

d. Was there any policy guidance, Operation Order (OPORDER), standard operating procedure (SOP), or other authority establishing criteria for providing detainee medical support and/or care in theater of operation?

e. What unit training did the active component (AC) receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

f. What unit training did the RC receive at home station, power projection platforms (PPP) and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

g. Identify OEF and OIF detention medical facilities.

h. With respect to the detention medical facilities identified in subparagraph g, determine if the facility generated, stored and collected detainee medical records to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.

i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?

j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.

k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?

l. Did any medical personnel aware of, or who treated actual or suspected, detainee abuse properly document the abuse?

m. To whom did any medical personnel aware of, or who treated, detainee abuse report such abuse?

n. Were there any theater or unit policies or established SOP's/Tactics, Techniques and Procedures (TTP) that specifically required medical personnel to report detainee abuse?

3-3. Assessment Focus. From the assigned Assessment Questions, the Team determined four areas of Assessment Focus:

a. Training.

b. Detainee medical policies and procedures.

c. Medical records management.

d. Incidence of and reporting of detainee abuse by medical personnel.

3-4. Methods

a. In formulating the assessment approach, the Team reviewed previous assessments related to detainee operations and investigations of detainee abuse as well as theater level and unit policies, Army regulations (AR) and field manuals (FM) outlining the precepts of detainee operations (included in Chapter 27, References). The Team reviewed numerous classified documents. The report purposefully cites only unclassified portions of classified documents. The use of these unclassified portions was coordinated with the Medical Research and Materiel Command Operations Division.

b. Based on the review, the Team identified an additional area of focus: the role of medical personnel in the detainee interrogation process.

c. A questionnaire-based measurement tool was determined to be an efficient and effective methodology for obtaining the desired information. Questionnaires with interview questions were developed based on the fourteen assessment questions and four assessment focus areas.

d. A signed Privacy Act Statement (Exhibit C, Annex 3) and Sworn Statement on DA Form 2823 were obtained from interviewees, as explained below.

e. The assessment methodology was designed with a three-pronged approach.

(1) *Training Questionnaires*

(a) *Student Questionnaire.* Used to assess detainee medical operations training at the AMEDDC&S. Not a Sworn Statement, not individual interviews. (Exhibit C, Annex 8)

(b) *PPP / CRC Questionnaire.* Used to assess detainee medical training conducted at the major PPP and CRC training sites. Not a Sworn Statement, individual interviews. (Exhibit C, Annex 6)

(c) *JRTC and NTC Questionnaire.* Used to conduct interviews at the JRTC and the NTC. Not a Sworn Statement, individual interviews. (Exhibit C, Annex 9)

(2) *Behavioral Science Consultation Team Questionnaire.* Used to interview personnel serving on BSCTs at GTMO and OIF (Abu Ghraib). Sworn Statement with individual interviews. (Exhibit C, Annex 7)

(3) *Past/Present Deploying Medical Personnel Questionnaire and Future Deploying Medical Personnel Questionnaire.* Used to interview medical personnel supporting detainee operations in maneuver, combat support, and combat service

support units preparing to deploy (future), those previously deployed (past) and personnel currently deployed (present) to obtain a wide-ranging perspective on the myriad of issues related to detainee medical operations, including a sampling of echelon level I, II and III care providers. After developing a set of core questions, customized questionnaires were developed for different duty positions working at the three levels of care in the past and present or future (Past/Present and Future Questionnaires). A questionnaire with additional questions was also developed to interview headquarters commanders. Sworn Statement with individual interviews. (Exhibit C, Annex 4 & 5)

f. In preparation for conducting the initial surveys and interviews, detainee medical records and detainee autopsy reports were reviewed. Information gleaned from this review provided a list of potential medical personnel for the Team to interview. The Team identified AC/RC units with past, present or future deployments to OEF, GTMO and OIF. The Team did not interview special operational units or special operations personnel. The Team then scheduled interviews and traveled to the units' locations to interview personnel.

3-5. Interviews and Units

a. The Team interviewed medical personnel in maneuver, combat support, and combat service support units in 22 states and 5 countries. The interviewees were in a past, present or future deployment status for OEF, GTMO, or OIF and included AC and RC personnel. For the current interviews, the Team visited the detention medical facilities in Afghanistan (Baghram) and Cuba (Guantanamo Bay). In Iraq, the Team met with the Commander, TF 134, and interviewed medical personnel supporting detainee operations at Abu Ghraib, Camp Danger, Camp Liberty and Camp Bucca. In Kuwait, the Team met with the CFLCC Deputy Commander and Chief of Staff, as well as the CFLCC Surgeon, to gain a perspective on the planning factors for detainee medical operations. For the past and future interviews, the Team traveled to units in 22 states and Germany. A leadership perspective on the issue of detainee medical operations was gained through interviews with medical personnel from command and control (C2) elements at corps, theater, and level I, II and III medical units. For training interviews, the Team visited faculty and students of training programs at the AMEDDC&S and the MI School, and trainers at NTC, JRTC, the two CRCs, and 12 PPPs. Additionally, lesson plans and other training materials were reviewed at these training sites.

b. A total of 1,182 questionnaires were completed in the following categories:

(1) *Student Questionnaires.* A total of 166 student questionnaires were completed at the AMEDDC&S, encompassing 20 91G (Patient Administration Specialist), 74 91W (Health Care Specialist), 17 91WM6 (Licensed Practical Nurse), 15 91X (Mental Health Specialist), and 40 OBC students. The findings, discussion, and recommendations are in Chapter 6.

(2) *PPP Questionnaires.* A total of 12 PPP Questionnaires were completed at Ft. Benning (1 Mobilization, 1 CRC), Ft. Bliss (1 MOB, 1 CRC), Ft. Carson (1 MOB), Ft. Dix

(1 MOB), Ft. Drum (1 MOB), Ft. Hood (1 MOB), Ft. Lewis (1 MOB), Ft. Polk (1 MOB), Ft. Riley (1 MOB), and Ft. Sill (1 MOB). The findings, discussion, and recommendations are in Chapters 8, 9 and 18.

(3) *JRTC and NTC*: Interviews were conducted at the JRTC (Ft. Polk) and NTC (Ft. Irwin). The findings, discussion, and recommendations are in Chapter 18.

(4) *BSCT Questionnaires*: Interviews were conducted with 11 past (6) and present (5) BSCT members assigned to GTMO (7) and OIF (4). The findings, discussion, and recommendations are in Chapter 18.

(5) *Past/Present and Future Questionnaires*. The team completed 993 interviews(80%AC/8%USAR/12%NG) with 803 (81%) interviews from units which previously served in OEF, GTMO or OIF (past), 77 (8%) currently serving in OEF, GTMO or OIF (present), and 113 (11%) preparing to mobilize to OEF, GTMO or OIF (future). The interviewees included 705 (71%) males and 288 (29%) females, including 522 (52.7%) officers, 3 (0.3%) warrant officers, and 468 (47%) enlisted personnel, with a mean age of 34.77 years. The findings, discussion, and recommendations are in following chapters of the report.

c. *Units*. A total of 180 units were sampled, as listed in Tables 3-1 through 3-6.

Table 3-1. OEF Medical Units

(b)(2)-2

Table 3-2. OEF Non-divisional Non-medical Units

(b)(2)-2

Table 3-3. OEF Divisional Non-medical Units

(b)(2)-2
(b)(2)-2

Table 3-4. OIF Medical Units

(b)(2)-2

Table 3-5. OIF Non-divisional Non-medical Units

(b)(2)-2

Table 3-6. OIF Divisional Non-medical Units

(b)(2)-2

Chapter 4.
Question a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?

4-1. Listed below are units who provided detainee care in OEF and OIF. The Team defined "providing detainee care" as any unit assigned medical resources that, at any time, provided care to at least one detainee. Also listed are the units of medical personnel who, at any time while in either theater, individually provided care to at least one detainee.

4-2. The list is not all-inclusive. The ability to capture 100% of the units involved in detainee care was a challenge. It was difficult to identify all the "one for one" medical personnel replacements and attachments. Another factor was the mission-required integration of non war-traced units. This included AC/RC medical units that were not previously configured to serve as a cohesive unit. Dates of service given were obtained from interviews and may not represent the exact period of service for the entire unit. The Team is confident that the below list is accurate and represents the scope and breadth of units that provided detainee care.

a. *Operation Enduring Freedom*

Non-Medical Units	Arrival	Departure
(b)(2)-2		

(b)(2)-2

(b)(2)-2

Medical Units	Arrival	Departure
(b)(2)-2		

b. *Operation Iraqi Freedom*

Non-medical Units	Arrival	Departure
(b)(2)-2		

(b)(2)-2

(b)(2)-2

(b)(2)-2

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Medical Units	Arrival	Departure
(b)(2)-2		

(b)(2)-2

(b)(2)-2

Chapter 5.
Question b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?

The answers to this question are found in Chapter 10 (Question g).

Chapter 6
Question c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?

Section I
Summary of Findings

6-1. Summary of Findings and Recommendations

a. Overall, less than 3% of medical personnel surveyed from the AC and 7% from the RC (past and present) medical personnel reported receiving training on detainee medical records. Refer to Table 6-4 to view AMEDDC&S student responses. A SME team comprised of individuals with exceptional knowledge of the generation, storage and collection (disposition) of detainee medical records should standardize training requirements and develop competency-based training for levels I-III in all theaters.

b. Overall, less than 15% of medical personnel from the AC, USAR, and NG (past and present) reported receiving MOS or other school training about reporting possible detainee abuse. Refer to Table 6-1 to view responses for OEF, GTMO and OIF. MEDCOM should appoint a SME team under the direction of the AMEDDC&S to develop the tasks and framework to build a comprehensive training program to train medical personnel on detention health care including medical reporting of detainee abuse with follow-up assessment of competency to measure effectiveness of training.

Section II
Training Received Regarding Generation, Storage and Collection of Detainee Medical Records

6-2. Findings

a. Less than 3% of medical personnel surveyed from the AC and 7% of the RC (past and present) reported receiving training on detainee medical records. Students surveyed in the OBC and four MOS -specific courses do receive training on medical records; however, there is minimal to no evidence that students receive training specific to the generation, storage and collection, and disposition of detainee medical records. See Table 6-4.

b. The majority (97%) of medical personnel surveyed from the AC and 93% from the RC that have served or are serving in OEF, GTMO, and OIF report they did not receive any school training on detainee medical records. See Table 6-1.

c. Of the nine PAD officers (MOS 70E) and ten PAD specialists surveyed, 30% reported receiving school training specific to detainee medical records in their courses.

d. The 70E Program Director offers a "Just-in-Time Deployment Training" course for deploying PAD officers (Cit. 4). The course curriculum mirrors the guidance in the MEDCOM memo entitled "Deployment Medical Documentation Guidance/Reporting Requirements."

e. The AMEDDC&S published a matrix listing lesson plans (LP) and courses that identify the tasks related to AR 190-8 (Cit. 6); however, AR 190-8 is cited in only one recent LP from the 91W10 course (Cit. 1). The regulation is stated as a reference in one exportable training package (Cit. 3). The most cited training reference in all courses on medical records is AR 40-66.

f. There is no exportable training specific to detainee medical records.

g. PAD officers and administrative specialists assigned to (Table of Organization and Equipment (TOE)) units are not afforded sufficient training opportunities to sustain their Area of Concentration (AOC) or MOS skills. The resulting lack of proficiency affects their capability to correctly maintain detainee records.

6-3. Discussion

a. *General Questionnaire*. Question 69. Have you received MOS or other school training about detainee medical records?

(1) The responses for OEF, GTMO and OIF, for past, present and future deployers, in the AC and RC combined, are presented in Table 6-1.

Table 6-1. Question 69. Have you received MOS or other school training on detainee medical records? [for AC/USAR/NG combined].

	YES	NO	UNK	N/A
OEF – Past (63)	3 (4.8%)	60 (95.2%)	0 (0%)	0 (0%)
OEF – Present (14)	1 (14.3%)	13 (100%)	0 (0%)	0 (0%)
OEF – Future (26)	1 (4%)	25 (96%)	0 (0%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	1 (14.3%)	6 (85.7%)	0 (0%)	0 (0%)
OIF – Past (729)	24 (3.3%)	698 (95.7%)	3 (0.4%)	4 (0.5%)
OIF – Present (52)	1 (1.9%)	51 (98.1%)	0 (0%)	0 (0%)
OIF – Future (84)	6 (7.1%)	75 (89.3%)	3 (3.6%)	0 (0%)

(2) *AC and RC Response*

(a) AC. Overall, 2.9% of 710 interviewees (past and present) and 2.7% of 73 (future) interviewees reported receiving MOS or other school training on detainee medical records.

(b) RC. Overall, 7% of 157 interviewees (past and present) and 0% of 37 (future) reported receiving MOS or other school training on detainee medical records.

b. *Student Questionnaire*. A total of 166 student questionnaires were completed at the AMEDDC&S, encompassing the OBC, 91G, 91W, 91WM6, and 91X students, as in Table 6-2. For all courses, the instruction had included training in the Geneva Conventions, the Law of War, and AR 190-8. Questionnaires were not executed for the Career Captains Course (CCC) as they had not received the training during the time period of the assessment. The results for questions pertinent to detainee medical records are presented in Tables 6-2 through 6-5. Students responding "yes" to question 603 (Table 6-3) were asked questions 608 and 611.

Table 6-2. Students participating in the Student Questionnaire.

Course	Number of Students	Week in Course
OBC	40	Week 10
91G	20	Week 5
91W	74	Week 15
91WM6	17	Week 6
91X	15	Week 10

Table 6-3. Question 603. At this point in your current course, has the training included AR 190-8 (Enemy Prisoners of War (EPW), Retained Personnel (RP), Civilian Internees (CI), and other Detainees).

	YES	NO	UNK	N/A
OBC (40)	33 (83%)	4 (10%)	3 (8%)	0 (0%)
91G (20)	6 (30%)	13 (65%)	1 (5%)	0 (0%)
91W (74)	57 (77%)	12 (16%)	5 (7%)	0 (0%)
91WM6 (17)	11 (65%)	4 (24%)	2 (12%)	0 (0%)
91X (15)	2 (13%)	7 (47%)	5 (33%)	1 (7%)

Table 6-4. Question 608. Did the training include requirements for medical records keeping for a detainee population?

	YES	NO	UNK	N/A
OBC (33)	20 (61%)	10 (30%)	3 (9%)	0 (0%)
91G (6)	3 (50%)	3 (50%)	0 (0%)	0 (0%)
91W (57)	12 (21%)	31 (54%)	14 (25%)	0 (0%)
91WM6 (11)	3 (27%)	6 (55%)	2 (18%)	0 (0%)
91X (2)	0 (0%)	1 (50%)	1 (50%)	0 (0%)

Table 6-5. Question 611. To what extent did the training raise your comfort level with accurately documenting medical records on a detainee?

	Excellent	Good	Neutral	Fair	Poor	None
OBC (33)	0 (0%)	9 (27%)	9 (27%)	9 (27%)	5 (15%)	1 (3%)
91G (6)	1 (33%)	2 (17%)	3 (50%)	0 (0%)	0 (0%)	0 (0%)
91W (57)	0 (0%)	12 (21%)	15 (26%)	8 (14%)	11 (19%)	11 (19%)
91WM6 (11)	0 (0%)	1 (9%)	5 (45%)	1 (9%)	4 (36%)	0 (0%)
91X (2)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)

c. *LPs and Course Content* (Cit. 6)

(1) LPs in the following professional development courses and MOS specific courses were reviewed: OBC, CCC, AC/RC Basic Non-commissioned Officer (BNCOC), Advanced Non-commissioned Officer Course (ANCOC), Medical Evacuation Doctrine Course, Flight Medic Course, Combat Casualty Care Course (C4), and Preventive Medicine Courses. None of these courses actually cite AR 190-8 or any DoD detention regulation outside of the DA 40 series regulations. The course content does address tasks related to AR 190-8; for example, General Protection Policy, captivity of EPW/RP, evacuation and care of EPW and RP, operation of EPW internment facilities and management, punitive jurisdiction, transfer of Prisoners of War, and medical care and sanitation. Other specialty courses offer medical ethics, ethical decision making, or ethics theory presentations. Only one LP, the International Humanitarian Law and the Geneva Conventions draft LP (draft dated 30 March 2005), which is taught into the 91W10 course, cites AR 190-8 (Cit. 1).

(2) The AMEDDC&S Doctrine and Training Development's new exportable training package, Medical Ethics of Detainee Care, cites AR 190-8. The exportable training package presentation mentions that documentation on medical records for

detainees is the same as for U.S. Soldiers, citing AR 40-66 as the reference. Although AR 190-8 is stated in the presentation, the tasks required to document medical screening, generation, storage and collection of detainee medical records are not stated. AR 40-66 is also in many of the courses' programs of instruction (POI). It is unknown if the content of MEDCOM memorandum entitled "Deployment Medical Documentation Guidance/Reporting Requirements" (office symbol MCHS-I, undated and unsigned) provides guidance and establishes procedures and responsibilities specific to detainee inpatient and outpatient records (Cit. 32). The content of this memorandum is not taught in any of the courses outside of the "PAD Just-in-Time Deployment Training" course.

d. *PAD Training*

(1) The course director and the assistant course director at the 70E course were interviewed. They provided a draft itinerary of the PAD "Just-in-Time Deployment Training" course (Cit. 4) and a copy of the slides for a course entitled "Medical Documents in Combat and Contingency Operations" (Cit. 5). The objectives of the course are to "(1) identify U.S. Army policies regarding medical records ownership and custody in accordance with (IAW) AR 40-66, (2) identification of the deployment management process of the Adult Preventive and Chronic Care Flow sheets (DA2766) and (3) the purpose and management of field and 'drop' files." Subsequent slides discuss the forms that make up the "field" file, inpatient treatment record, and "drop" file. The course also stressed that, if the Theater/Area of Responsibility (AOR) surgeon considers it impractical, the inpatient treatment record will not be used. Indications for use of Field Medical Card (DD1380) are presented in the course.

(2) PAD officers expressed concerns about maintaining proficiency for TOE 70E and 91G personnel. Skills training and sustainment have not been a unit priority. Other unit duties and responsibilities of these medical personnel have limited their opportunities for training. One officer reported developing a program to ensure her 91G personnel received proficiency training prior to deployment. The resulting lack of proficiency affects their capability to correctly maintain detainee records.

6-4. Recommendations

a. AMEDDC&S should ensure standardization of training of detainee healthcare documentation and disposition of retired detainee records across the entire healthcare spectrum in all theaters, from the point of capture and collection point to the detention facilities.

b. Establish a team under the direction of the AMEDDC&S comprised of clinicians and PAD expertise with exceptional knowledge of the generation, storage, maintenance and collection (disposition) of detainee medical records from the point of capture, collection point to the detention facilities. The tasks and training content should be developed by this team. The AMEDDC&S should facilitate this process.

(1) The above team should analyze courses' POIs and LPs to determine training gaps in the generation, storage and collection of detainee medical records.

(2) The training should include a crosswalk of Geneva Conventions, DoD and DA regulations and policies pertaining to the generation, storage and collection of detainee medical records. Training content should be regularly revised to reflect changes in the policies.

(3) The training structure should include all levels of care, from point of capture and the collection point to the detention facilities. Training should incorporate AC/RC Table of Distribution and Allowance (TDA) and TOE medical units and medical assets in MP and maneuver units.

c. Create and deploy an exportable training package specific to the generation, storage and collection of detainee medical records for medical personnel in AC/RC TDA and TOE medical units. Medical assets assigned to AC/RC MP and maneuver units should receive the training package.

d. PAD officers and senior PAD specialists should serve as the SMEs and training resource for AC/RC level II and III units. The physician assistant (PA) or senior 91W should serve as the training resource for non-medical units.

e. Incorporate training that is focused on the generation, storage and collection of detainee medical records into the 70E and 91G courses.

f. Expand PAD "Just-in-Time Deployment Training" course to include deploying RC 70E and 91G personnel.

g. Develop sustainment and proficiency training for 70E and 91G personnel in AC/RC units. Training and proficiency data for 70E and 91G personnel should be competency-based and reported regularly as part of the unit's readiness report.

Section III
Training Received Regarding Medical Reporting of Detainee Abuse

6-5. Findings

a. 94% or more of medical personnel report familiarization with the Geneva Conventions.

b. 97.5% of OBC Army Nurse officers surveyed reported receiving training on Geneva Conventions and Law of War. See Table 6-10.

(1) Approximately one-quarter of the students enrolled in the 91G course reported receiving Geneva Conventions and one-third reported receiving Law of War training.

(2) Eighty-five percent (85%) of students in the 91W course reported receiving the Geneva Conventions training, although little more than one-half of the students reported receiving Law of War training.

(3) Fifty-nine percent (59%) of 91WM6 students reported receiving Geneva Conventions and less than half reported receiving Law of War training.

(4) Two of the 15 91X students reported receiving Geneva Conventions training and three of the fifteen students reported receiving Law of War training.

e. Less than half of all students reported that training included a process of medical reporting for suspected detainee abuse. Students who reported receiving the training reported that the training raised their comfort level with medical reporting of suspected detainee abuse. Refer to Tables 6-14 and 6-15 to view students' responses.

f. The LPs listed in the AMEDDC&S Review of Institutional Training matrix do not discuss actual or suspected abuse. The plans also do not contain case studies or scenarios requiring students to apply newly learned concepts to situations in which abuse may not be readily apparent. There are no known "approved" scenarios or case studies that role play actual or suspected abuse and the reporting process. LPs do not address the care and the complexity of care and resources at the point of capture, collection point and at detention facilities. AR 190-8 is cited as a reference in LP but cited in only one presentation.

g. There are no pocket training aids to serve as a quick reference training guide for students or deploying medical units that identify medical personnel responsibilities for reporting actual or suspected abuse of detainees.

h. There is no evidence that training content has been developed and or vetted by Service members with exceptional knowledge of detainee care at the point of capture, collection point and detention facilities with representation from a judge advocate, a medical ethicist, and SME serving in the prison health care system.

i. Several LPs have been recently updated. Lectures such as medical ethics have been added.

6-6. Discussion:

a. *General Questionnaire.* Tables 6-6 through 6-15 depict responses to questions pertaining to training received regarding medical reporting of detainee abuse.

(1) Question 51. Have you received MOS or other school training about reporting possible detainee abuse?

(a) For AC/USAR/NG combined, data is presented in Table 6-6.

Table 6-6. Question 51. Have you received MOS or other school training about reporting possible detainee abuse? [for AC/USAR/NG combined].

	YES	NO	UNK	N/A
OEF – Past (63)	9 (14%)	52 (83%)	2 (3%)	0 (0%)
OEF – Present (15)	1 (7%)	12 (80%)	2 (15%)	0 (0%)
OEF – Future (25)	4 (16%)	21 (84%)	0 (0%)	0 (0%)
GTMO – Past (2)	1 (50%)	1 (50%)	0 (0%)	0 (0%)
GTMO – Present (7)	2 (29%)	5 (71%)	0 (0%)	0 (0%)
OIF – Past (738)	108 (15%)	613 (83%)	17 (2%)	0 (0%)
OIF – Present (55)	6 (11%)	49 (89%)	0 (0%)	0 (0%)
OIF – Future (85)	27 (32%)	56 (66%)	2 (2%)	0 (0%)

In all categories of personnel, 50% or more had not received this school training.

(b) AC and RC responses

(i) AC. 14% of 721 surveyed (past and present) and 30% of 72 (future) surveyed reported receiving MOS or other school training about reporting possible detainee abuse.

(ii) RC. 13% of 159 surveyed (past and present) and 21% of 38 (future) surveyed reported receiving MOS or other school training about reported possible abuse.

(2) Responses to other questions pertaining to training received regarding medical reporting of detainee abuse are in Tables 6-7 to 6-15.

Table 6-7. Question 1. Are you familiar with the Geneva Conventions?

	YES	NO	UNK	N/A
OEF – Past (63)	63 (100%)	0 (0%)	0 (0%)	0 (0%)
OEF – Present (14)	14 (100%)	0 (0%)	0 (0%)	0 (0%)
OEF – Future (25)	26 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	7 (100%)	0 (0%)	0 (0%)	0 (0%)
OIF – Past (735)	730 (99.3%)	2 (0.3%)	3 (0.4%)	0 (0%)
OIF – Present (55)	54 (98%)	0 (0%)	1 (2%)	0 (0%)
OIF – Future (88)	83 (94%)	4 (5%)	1 (1%)	0 (0%)

In all categories of personnel, 94% or more were familiar with the Geneva Conventions.

Table 6-8. Question 2. In preparation for providing detainee care did your unit use case studies?

	YES	NO	UNK	N/A
OEF – Past (63)	17 (27%)	41 (65%)	5 (8%)	0 (0%)
OEF – Present (13)	2 (15%)	11 (85%)	0 (0%)	0 (0%)
OEF – Future (26)	18 (69%)	5 (19%)	3 (12%)	0 (0%)
GTMO – Past (2)	1 (50%)	1 (50%)	0 (0%)	0 (0%)
GTMO – Present (7)	5 (71%)	2 (29%)	0 (0%)	0 (0%)
OIF – Past (723)	147 (20.3%)	501 (69.2%)	72 (9.9%)	3 (0.4%)
OIF – Present (52)	11 (21%)	37 (71%)	4 (8%)	0 (0%)
OIF – Future (85)	26 (31%)	50 (59%)	8 (9%)	1 (1%)

In all categories, there is an increasing trend of using case studies in this training from past to present to future deploying personnel.

Table 6-9. Question 3. Did your overall unit training prepare you for addressing human rights issues of detainees?

	YES	NO	UNK	N/A
OEF – Past (63)	45 (71%)	17 (27%)	1 (2%)	0 (0%)
OEF – Present (14)	6 (43%)	0 (57%)	0 (0%)	0 (0%)
OEF – Future (26)	22 (85%)	3 (12%)	1 (4%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	6 (86%)	1 (14%)	0 (0%)	0 (0%)
OIF – Past (734)	473 (64%)	237 (32%)	24 (3%)	0 (0%)
OIF – Present (55)	33 (60%)	21 (38%)	1 (2%)	0 (0%)
OIF – Future (87)	54 (62%)	28 (32%)	4 (5%)	1 (1%)

Except for present OEF personnel (43%), 60% or more of the personnel felt their unit training prepared them for addressing human rights issues of detainees.

b. *Student Questionnaire*. The results for questions pertinent to training received regarding medical reporting of detainee abuse are presented in Tables 6-10 through 6-15.

Table 6-10. Question 601. At this point in your current course, has the training included the Geneva Conventions?

	YES	NO	UNK	N/A
OBC (40)	39 (97.5%)	1 (2.5%)	0 (0%)	0 (0%)
91G (20)	5 (25%)	9 (45%)	6 (30%)	0 (0%)
91W (74)	63 (85%)	8 (11%)	3 (4%)	0 (0%)
91WM6 (17)	10 (59%)	6 (35%)	1 (6%)	0 (0%)
91X (15)	2 (13%)	6 (40%)	6 (40%)	1 (7%)

For 91G and 91X courses, one-quarter or less of the students recalled receiving training on the Geneva Conventions.

Table 6-11. Question 609. Did the training include the specifics of medical reporting of detainee abuse? Answers for students responding "yes" to Question 601 who answered this question.

	YES	NO	UNK	N/A
OBC (39)	16 (41%)	19 (49%)	4 (10%)	0 (0%)
91G (4)	2 (50%)	2 (50%)	0 (0%)	0 (0%)
91W (63)	22 (35%)	31 (49%)	10 (16%)	0 (0%)
91WM6 (10)	6 (60%)	3 (30%)	1 (10%)	0 (0%)
91X (2)	0 (0%)	2 (100%)	0 (0%)	0 (0%)

Responses for 91G and 91X are unreliable due to small sample size. For the other courses, except for 91WMG (60%), less than half of the students recalled receiving this training.

Table 6-12. Question 612. To what extent did the training raise your comfort level with medical reporting of detainee abuse? Answers for students responding "yes" to Question 601 who answered this question.

	Excellent	Good	Neutral	Fair	Poor	None
OBC (39)	1 (3%)	13 (33%)	11 (28%)	8 (21%)	4 (10%)	2 (5%)
91G (5)	1 (20%)	2 (40%)	2 (40%)	0 (0%)	0 (0%)	0 (0%)
91W (60)	0 (0%)	13 (22%)	17 (28%)	10 (17%)	9 (15%)	11 (18%)
91WM6 (10)	0 (0%)	3 (30%)	4 (40%)	1 (10%)	0 (0%)	2 (20%)
91X (2)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	1 (50%)

Responses for 91G and 91X are unreliable due to small sample size. Overall, the training did not produce a good or excellent comfort level for reporting detainee abuse.

Table 6-13. Question 602. At this point in your current course, has the training included the Law of War?

	YES	NO	UNK	N/A
OBC (40)	40 (100%)	0 (0%)	0 (0%)	0 (0%)
91G (20)	7 (35%)	12 (60%)	1 (5%)	0 (0%)
91W (74)	42 (57%)	14 (19%)	18 (24%)	0 (0%)
91WM6 (17)	7 (41%)	7 (41%)	3 (18%)	0 (0%)
91X (15)	3 (20%)	6 (40%)	5 (33%)	1 (7%)

For 91G and 91X courses, one-third or less of the students recalled receiving training on the Law of War.

Table 6-14. Question 609. Did the training include the specifics of medical reporting of detainee abuse? Answers for students responding "yes" to Question 602 who answered this question.

	YES	NO	UNK	N/A
OBC (40)	17 (43%)	19 (48%)	4 (10%)	0 (0%)
91G (6)	3 (50%)	3 (50%)	0 (0%)	0 (0%)
91W (42)	16 (38%)	19 (45%)	7 (17%)	0 (0%)
91WM6 (7)	5 (60%)	2 (71%)	0 (29%)	0 (0%)
91X (3)	1 (33%)	2 (67%)	0 (0%)	0 (0%)

Responses for 91X are unreliable due to small sample size. For the other courses, except for 91WMG (60%), half or less of the students recalled receiving this training.

Table 6-15. Question 612. To what extent did the training raise your comfort level with medical reporting of detainee abuse? Answers for students responding "yes" to Question 602 who answered this question.

	Excellent	Good	Neutral	Fair	Poor	None
OBC (40)	1 (3%)	13 (33%)	11 (28%)	9 (21%)	4 (10%)	2 (5%)
91G (7)	2 (29%)	2 (29%)	2 (29%)	0 (0%)	0 (0%)	1 (14%)
91W (41)	0 (0%)	8 (20%)	11 (27%)	9 (22%)	5 (12%)	8 (20%)
91WM6 (7)	1 (11%)	2 (22%)	3 (33%)	1 (11%)	1 (11%)	1 (11%)
91X (2)	0 (0%)	1 (33.3%)	0 (0%)	1 (33.3%)	0 (0%)	1 (33.3%)

Responses for 91X are unreliable due to small sample size. Overall, the training did not produce a good or excellent comfort level for reporting detainee abuse.

(1) *Comments from Surveyed Students.* About half of the OBC and 91W and less than half of the 91WM6 students surveyed requested interactive real world examples through scenario based training. One student requested a pocket reference guide. Another student requested written and on-line references for further research on the subject matter. Many students desired more detail and complexity in the scenarios to provide them the opportunity to discuss the issues in depth. Students particularly wanted to hear the personal stories of the Soldiers and their experiences.

(2) *Program of Instructions/LPs.* Review of the courses' POIs and LPs indicate that students attending professional development, MOS specific courses, and specialty courses do receive Geneva Conventions and Law of War training. LPs do not address physical and psychological examinations/medical screening for abuse, cultural

considerations and language barriers, use of interpreters and limitations, interrogations and medical personnel's responsibilities, detainee medical record documentation and disposition, emotional aspects in caring for detainees, signing of death certificates, distinguishing between abuse and lawful combat operations, and use of case studies or scenario-play (Table 20).

d. *Other AMEDD Center And School Training Products*

(1) Interviews with staff members at the Department of Training Support, AMEDD C&S, revealed a team dedicated to the Dean's charge to quickly move education and knowledge outside the Academy walls to the AMEDD population worldwide. In January 2005, 200 sets of AMEDD training CDs were distributed to units in Iraq. The training products are provided on request from the field. As of 24 March 2005, Department of Training Support was processing orders from MEDCOM, Forces Command (FORSCOM), and USAR units in addition to Navy active duty units and personnel. The first set was completed in less than four weeks. The next goal is to develop current instructional materials into an exportable distance learning formats. Content will be reviewed yearly or sooner if required by the dynamic environment and needs of the AMEDD personnel (Cit. 3).

(2) The Medical Ethics in Detainee Operations (Cit. 2) provides a cursory overview of the Just War Theory, explanation of the Red Cross/Red Crescent, challenging unlawful orders and war crimes, treatment of detainees under medical roles of care, battlefield triage and evacuation categories. Scenarios presented are easily recognizable as war crimes. The scenarios infer that Soldiers know that the order is unlawful and takes the reader through the steps to challenge the order and contact the chain of command. In contrast, more subtle incidents that present ethical and professional dilemmas such as a 91W fluent in Arabic in which he has been directed to question detainees by his medical Officer in Charge (OIC) to obtain more intelligence information or a medic that initiates intravenous therapy on a dehydrated detainee during an interrogation or a physician which obtains a buccal swab under the direction of the interrogator. The detainee is informed by the interrogator that the swab will link him to terrorist activities. These incidents are examples of incidents which could be incorporated into LPs for further probing and discussion by students and instructors.

6-6. Recommendations

a. Tools should be introduced to assist students in recalling their training; for example, a reference pocket training aid. The tool should display a decision algorithm to assist them in distinguishing actual or suspected abuse from injuries as a result of lawful combat operations.

b. AMEDDC&S, as the proponent for training of medical personnel in detainee healthcare (to include medical reporting of detainee abuse) across the entire healthcare spectrum in theater, from the point of capture and collection point to a detention facility should:

(1) Establish a SME team to develop the tasks and framework to build a comprehensive AMEDD training program. The framework should include all training platforms (Mobilized Unit Inprocessing Centers (MUIC), Reserve Training Sites (RTS), NTC, JRTC, and PPP sites) and methods of instruction (lecture, case studies, scenario, after action review (AAR)). The framework must encompass all levels of care, from point of capture to a detention facility. The framework must serve as an additional resource for TOE medical units and TDA facilities as part of the readiness component.

(2) SME Team membership should include appropriate representation from the RC and should have exceptional knowledge of detainee care at the point of capture, collection point and detention facilities. Additionally, the team should be comprised of a judge advocate, a medical ethicist, and SMEs serving in the prison health care system. The tasks and training content should be standardized particularly in the professional development and MOS specific courses.

(3) MOS-specific schools and professional development courses should incorporate case studies and scenario-based training on current Army operations. Training Centers, such as NTC and JRTC, should be provided with the means to provide realistic level I to level III detainee medical care training.

(4) Consider using regularly scheduled video teleconferences with 91W, 91WM6 students and Soldiers that experienced detainee care from the point of capture, collection point or detention facility to enhance learning followed with a Q and A format.

(5) Revise the existing exportable training package to include all tasks associated with detainee care. Incorporate selected incidents and allegations to serve as case studies or scenario play. The AMEDDC&S should facilitate development of the training package and push the products out.

c. MEDCOM should provide all medical senior leaders (AC/RC) detention care policies, regulations and references which could be accessed through the Army Knowledge Online (AKO) site. MEDCOM should continually update AKO so that evolving guidance, tools and references are current. The following criteria and content (not all inclusive) should be considered:

(1) Theater accessible.

(2) Approved for continuing education credit.

(3) Approved detention care competency tools.

(4) DoD detention care guidance.

(5) DA guidance relating to detention care.

(6) "Health Professional's Guide to Medical and Psychological Evaluation of Torture by Physician for Human Rights" as an example (Cit. 38).

d. DoD-I 1322.24, "Medical Readiness Training" (12 July 2002) (Cit. 21) should include detention care competencies. Competencies should be developed by SMEs possessing exceptional knowledge of detainee care at the point of capture, collection point and detention facilities and the prison health care system.

Chapter 7
Question d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?

7-1. General Findings

a. Present DA and DoD guidance regarding the standard of care for detainees has gaps, at times is ambiguous, and is not specific enough.

b. Many "Yes" respondents were unable to specifically identify policies or regulations, or provide details of the guidance contained therein.

c. AR 40-400 provides the best statement regarding health care standards.

7-2. Operation Enduring Freedom Findings

a. The Team found no evidence of **specific** theater-level policies for detainee medical operations in OEF until 2004.

b. 47% of past and 60% of current OEF personnel answered "Yes" to question (d) above.

7-3. Guantanamo Bay Detention Facility Findings

a. There have been numerous theater-level/facility policies for detainee medical operations since early 2003 (Cit. 26).

b. 100% of past and current GTMO personnel answered "Yes" to question (d) above.

c. All medical personnel interviewed on-site at GTMO were very well-versed in appropriate policies and procedures.

7-4. Operation Iraqi Freedom Findings

a. The team found no evidence of **specific** theater-level policies for detainee medical operations in OIF until 2004.

b. 56% of past and 88% of current OIF personnel answered "Yes" to question (d) above.

c. The current organization of detainee medical operations is under TF 134.

d. TF 134 has developed broad policy and guidelines for detainee medical care.

7-5. Discussion

a. The Team found evidence of confusion among medical personnel, both leaders and subordinates, of the required level of care for detainees. This confusion is explained by the use of different classifications for detained personnel. As discussed in paragraph 7-5d below, the guidance on the standard of care varies for different classifications of detainees.

b. Two Combat Support Hospital (CSH) Commanders (Interviewees # 634 and 715) stated they were instructed by their higher headquarters to provide detainee medical care based on local Iraqi standards. Despite this incorrect guidance, both CSHs provided detainees the correct level of care as stated in paragraph 7-5d(3) below.

c. Theater level guidance was not provided in a timely manner to deploying OEF and OIF medical units or personnel. Some units developed their own policies for providing detainee medical care, including most CSHs and TF Oasis. DoD and DA guidance is outlined below:

d. *Present DoD and DA Guidance*

(1) Health Affairs (HA) Policy 02-005, Medical Care for Enemy Persons under U.S. Control Detained in Conjunction with Operation Enduring Freedom, dated April 2002 (Cit. 28), states that medical care shall be provided consistent with AR 190-8 to the extent appropriate. The phrase "to the extent appropriate" is ambiguous. The policy also states that care for detainees shall be guided by standards **"similar to those that would be used to evaluate medical issues for US personnel."** The adoption of a "similar standard" is also ambiguous. HA Policy 02-005 references DoD Directive 2310.1, DoD Program for Enemy Prisoners of War and other Detainees, dated August 1994 (Cit. 22). DoD Directive 2310.1 does not include any specific information related to medical care.

(2) AR 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees, dated October 1997 (Cit. 11), presently contains the most detailed guidance on medical care to individuals under U.S. control. However, the vast majority of the brief medical information contained in this AR (Section 6-6) only pertains to CIs. The stated standard is "**The treatment must be as good as that provided for the general population.**" It is not clear if this section is intended to apply to all classes of detained persons. Medical information elsewhere in this AR pertaining to other classes of detainees is inadequate.

(3) AR 40-400, Patient Administration, dated March 2001 (Cit. 10), contains the clearest statement of the Army standard of medical care for detainees. Paragraph 3-38 states: **"Members of the enemy armed forces and other persons captured or detained by U.S. Armed Forces are entitled to medical treatment of the same kind and quality as that provided U.S. Forces in the same area."** Although misplaced (AR 40-3 and AR 190-8 would be the logical locations), this is a succinct statement that

is easy to comply with and understand. Not one single interviewee, nor any Team member prior to this assessment, knew of the existence of paragraph 3-38.

(4) AR 40-3, Medical, Dental, and Veterinary Care, dated November 2002 (Cit. 8), and AR 40-66, Medical Records Administration and Health Care Administration, dated July 2004 (Cit. 9), contain **no** guidance regarding detainee care.

(5) Secretary of Defense (SECDEF) Memorandum, SUBJECT: Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the U.S., dated June 2004 (Cit. 41), clearly states the procedures for death investigations for detainees in the custody of the Armed Forces, including the requirement for an autopsy.

(6) Deputy Secretary of Defense Memorandum, SUBJECT: Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees under DoD Control, dated January 2005 (Cit. 20), provides clear direction on body searches.

e. *Operation Enduring Freedom*

(1) Combined Joint Task Force (CJTF) -76 BHA and KHA Detainee Medical Standard Operating Procedure (SOP), dated August 2004 (Cit. 17), contains some areas of very specific guidance (e.g. tuberculosis screening, sick call procedures, and inprocessing). However, some confusing paragraphs include: "patients with life, limb, or eye emergencies like heart attacks or stroke will be referred to the medic on duty and if the medic decides that the complaint can wait, the PUC will be seen the following day," and one paragraph describing the assessment of detainees prior to interrogation.

(2) Bagram SOP, Annex W-1, dated September 2004 (Cit. 12), contains two pages on specific medical issues, including: in-processing, sick call, monthly exams, GTMO transfer, pharmacy, and preventive medicine. Medical screening and exam forms have been developed.

(3) CJTF-76, Detainee Operations SOP's, Bagram (Secret), dated January 2005, has minimal information on medical care but includes: (U) **"Care will be provided to the same extent provided by CJTF-76 to its own forces."** Other medical issues covered include: sick call, hunger strikes, the taking of photos, and access to medical records.[1]

(4) U.S. Southern Command (USSOUTHCOM) Confidentiality Policy for Interactions between Health Care Providers and Enemy Persons under U.S. Control, Detained in Conjunction with OEF, dated August 2002 (Cit. 42), references AR 190-8 and the Geneva Conventions, but contains vague and potentially ambiguous wording:

[1] "Only those individuals identified as requiring knowing the detainee's medical condition will have access to the medical records." The SOP does not define the criteria used to determine who has a "need to know."

(a) This policy states "**Medical care is provided under conditions and for purposes similar to those applicable to military correctional facilities**," without citing any references to support this standard.

(b) The standard in 3(a) above has been supplemented by the USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at U.S. Naval Base Guantanamo Bay, Cuba, dated 9 August 2004. Paragraph 10c states: "Medical care and treatment shall be provided whenever necessary." Paragraph 10g states: "U.S. accepted standards of medical care (current practice guidelines) are used."

f. *Guantanamo Bay Detention Facility*

(1) USSOUTHCOM Policy on Healthcare Delivery to Enemy Persons under U.S. Control at US Naval Base, Guantanamo Bay, Cuba, dated August 2004 (Cit. 43), includes: "**U.S. accepted standards of medical care are used.**"

(2) There are numerous SOPs from the Detainee Hospital, GTMO, from 2003 and 2004 (Cit. 27). Several specific ones that could be referred to in the future as potential standards in all theaters include: Detainee Weight Management and Nutrition Program, In-Processing Medical Evaluation, Detainee Refusal of Care, and Vaccinations.

g. *Operation Iraqi Freedom*

(1) ANNEX Q (Medical Services) to U.S Army Central Command (USARCENT) Operation Plan (OPLAN) 1003-96 (Secret), dated April, 1997: (U) **"Provide health services for CI's and EPW's at established camps as governed by customary and conventional international law."** It does not specifically reference AR 190-8, nor does it explain what is meant by this statement.

(2) Appendix 7 (Medical) to ANNEX I to V Corps OPLAN 1003 (Secret), dated December, 1998: (U) **"EPWs, CIs, and Detained Persons (DETS) are provided medical treatment on the same basis as US sick and wounded. Medical factors are utilized to determine the priority of treatment."**

(3) Fragmentary Order (FRAGO) 1206 to CJTF-7 Operation Order (OPORD) 03-036 (Secret), dated December 2003, states: (U) "Establish and staff a 50 bed facility which will provide level I-III care for security detainees IVO Abu Ghraib NLT 15 February 2004."

(4) FRAGO 20 to FORSCOM Deployment Orders in Support of OIF-2 (Secret), dated May 2004, (U) recognizes and addresses the shortfall of not having a dedicated level III facility specifically for detainee care.

(5) Camp Bucca SOP, dated June 2004, sec. 4-4: "Detainee Medical Procedures" (Cit. 14), covers numerous areas in generalities, including: roles of different medical personnel, in-processing, sick call, medical records (access shall be restricted and

governed IAW AR 340-16 and 340-21), medical evacuation, detainee deaths, preventive medicine operations, and dental care.

(6) Appendix 2 (Medical Care for Detainee Operations) to ANNEX Q (Health Services Support) to Multinational Corps, Iraq (MNC-I) CAMPAIGN PLAN: OIF (Secret), dated August 2004.

(7) ANNEX Q (Health Services Support) to USCENTCOM OPORDER 11 to Multi-National Forces-Iraq (MNF-I) (Secret), dated December, 2004, includes: (U) **"EPWs, CIs, and SDs (Security Detainees) will be provided medical treatment on the same basis as Multinational Forces, Iraq (MNF-I) sick and wounded,** and IAW existing treaties, international law, and the Geneva Convention. Standard military triage protocols will be used to determine the priority of treatment to be administered. To the extent possible, EPWs, CIs, and SDs will be treated in separate wards from MNF-I patients, subject to physical constraints. Detained enemy medical personnel may be used as much as possible in the care of EPW's."

(8) MNF-I Policy 05-02, "Interrogation Policy" (Secret), encl.1, "Safeguards," dated January 2005, includes:

(a) (U) "Detainee medical information will be protected in accordance with all applicable laws and regulations. Routine detainee healthcare is separated from interrogation operations. Healthcare providers for detained persons will not be required to verbally provide detainee medical information to intelligence collectors. This applies to all agencies conducting interrogations. Medical personnel shall provide interrogators such information as they believe necessary to protect the health and safety of the detainee or to prevent the commission of a crime."

(b) (U) "Detained persons selected for interrogation must undergo a medical exam or assessment before the beginning of interrogation. The exam or assessment will record the physical and medical condition of the detainee and ensure the detainee is medically cleared to undergo interrogation."

(c) (U) "No interrogation of hospitalized detained persons may be conducted without first obtaining the approval of DCGDO/Commander, TF 134, in conjunction with the DCCS at the hospital."

(d) (U) "Interrogation of wounded personnel will not delay or interfere with the evacuation of wounded personnel to the appropriate level of medical care."

(9) OIF Theater Detention Healthcare Policy, dated January 2005, with multiple appendixes (Cit. 37); per Commander, Detainee Medical TF, and Commander, TF 44th MEDCOM; is very comprehensive and covers the major areas of detainee medical operations.

(10) MNF-I SOP: Detainee Healthcare, dated February 2005 (Cit. 34); mirrors # 9 above.

(11) TF 134 Memorandum, SOP for Ensuring Separation of Detention Operations Functions, dated February 2005 (Cit. 46); reinforces the need to protect detainee medical information.

7-6. Recommendations.

a. Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency. Specific areas of guidance should include, but are not limited to:

(1) Initial and continual screening assessments.

(2) Medical care equal to standards for U.S. Soldiers in the theater of operation.

(3) Informed consent.

(4) Protection of detainee medical information.

(5) Documentation in and handling of medical records.

(6) Recognition, documentation, and reporting of suspected abuses.

(7) Planning factors for medical resources required for detainee care.

b. All medical personnel must be trained on this guidance, with follow-up assessment of competency.

c. Policies concerning detainee medical operations should be declassified to the greatest extent possible to allow for the widest application of recommendation (a) above.

d. Classified policies should be archived on secure command web pages as they are updated or as new ones are added, since this will allow one to evaluate policy implementation timelines.

e. Units having theater-level responsibilities (for example TF 134), should propagate DA or DoD guidance, with particular emphasis on units delivering level I or II care in their AOR.

Chapter 8
Question e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records[1] and the medical reporting of detainee abuse?

Section I
Operation Enduring Freedom

8-1. Findings

a. *Training on Detainee Medical Records.* Very few past/present OEF interviewees received medical records training prior to deployment; 32% received this training in theater. For future OEF deployers, almost two-thirds of the interviewees received unit training at their home stations.

b. *Training on Detainee Abuse Reporting.* Few past/present OEF interviewees received detainee abuse reporting training prior to deployment; 42% received this training in theater. For future OEF deployers, most of the interviewees received unit training at their home stations.

c. Few interviewees stated they had prior knowledge their deployment would include a detainee medical mission in theater.

8-2. Discussion

a. *Training on Detainee Medical Records.*

(1) 38 AC past/present OEF medical personnel were interviewed.

(a) 5% reported receiving unit training at home station (Question 70).

(b) 5% reported receiving unit training during mobilization (Question 71).

(c) 32% reported receiving unit training in theater (Question 72).

(2) Of 26 AC future OEF-deploying soldiers, 62% stated they received unit training at their home station about detainee medical records (Question 70).

b. *Training on Detainee Abuse Reporting.*

(1) 38 AC past/present medical personnel were interviewed.

(a) 18% reported receiving unit training at home station (Question 52).

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[1] As noted in paragraph 6-2a, 2.8% of 692 AC interviewees surveyed (past and present) and 2.7% of 73 (future) reported receiving MOS or other school training on detainee medical records.

(b) 24% reported receiving unit training during mobilization (Question 53).

(c) 42% reported receiving unit training in theater (Question 54).

(2) Of 26 AC future OEF-deploying soldiers, 92% stated they received unit training at their home station about reporting possible detainee abuse (Question 52). This large improvement over the past/present personnel, according to many future interviewees, is directly attributable to the publicity, and lessons-learned, from Abu Ghraib.

Section II
Guantanamo Bay Detention Facility (GTMO)

8-3. Findings

a. *Training on Detainee Medical Records.* Very few past/present GTMO interviewees received medical records training prior to deployment; 71% received this training in theater.

b. *Training on Detainee Abuse Reporting.* Over 50% of past/present GTMO interviewees received detainee abuse reporting training prior to deployment; 71% received this training in theater.

c. Interviewees were aware of their detainee mission prior to deploying.

8-4. Discussion

a. *Training on Detainee Medical Records.*

(1) Seven AC past/present GTMO medical personnel were interviewed:

(a) 14% reported receiving unit training at home station (Question 70).

(b) 0% reported receiving unit training during mobilization (Question 71).

(c) 71% reported receiving unit training in theater (Question 72).

(2) No interviews were conducted on GTMO future deploying individuals.

b. *Training on Detainee Abuse Reporting.* Training on detainee abuse reporting

(1) Seven AC past/present GTMO medical personnel were interviewed:

(a) 57% reported receiving unit training at home station (Question 52).

(b) 71% reported receiving unit training during mobilization (Question 53).

(c) 71% reported receiving unit training in theater (Question 54).

(2) No interviews were conducted on GTMO future deploying individuals.

Section IV
Operation Iraqi Freedom

8-5. Findings

a. *Training on Detainee Medical Records*. Very few past/present OIF interviewees received medical records training prior to deployment; 27% received this training in theater. For future OIF deployers, 27% of the interviewees received unit training at their home stations.

b. *Training on Detainee Abuse Reporting*. Less than one-quarter of the past/present OIF interviewees received detainee abuse reporting training prior to deployment; 40% received this training in theater. For future OIF deployers, 32% of the interviewees received unit training at their home stations.

c. Most OIF interviewees stated they had no prior knowledge their deployment included a detainee mission in theater. Only one unit knew of a specific detainee mission awaiting them in theater.

8-6. Discussion

a. *Training on Detainee Medical Records*. Training on detainee medical records:

(1) 644 AC past/present OIF medical personnel were interviewed.

(a) 3% reported receiving unit training at home station (Question 70).

(b) 5% reported receiving unit training during mobilization (Question 71).

(c) 27% reported receiving unit training in theater (Question 72).

(2) Of 47 AC future OIF deploying personnel interviewed, 15% stated they received unit training at their home station about detainee medical records (Question 70).

b. *Training on Detainee Abuse Reporting*. Training on detainee abuse reporting:

(1) 658 AC past/present OIF medical personnel were interviewed.

(a) 18% reported receiving unit training at home station (Question 52).

(b) 24% reported receiving unit training during mobilization (Question 53).

(c) 40% reported receiving unit training in theater (Question 54).

(2) Of 47 AC OEF future deploying soldiers, 32% stated they received unit training at their home station about reporting possible detainee abuse (Question 52).

c. The (b)(2)-2 personnel knew they were deploying to a specific detainee mission in theater before deploying; however, they did not conduct additional pre-deployment training related to detainee healthcare before departing for Iraq other than their mandatory PPP training. Strong hospital and company-level leadership combined with committed support from the 44th MEDCOM has helped offset this training oversight. The unit has helped draft the first comprehensive detainee healthcare operations policies and SOPs in OIF (Cit. 37). According to interviewees, other units not providing their soldiers with additional pre-deployment training have not fared as well in theater.

Section VI
Recommendations

8-7. Overall Recommendations

a. Leaders at all levels should conduct meaningful training and verify by following up with an assessment via a competency test, regardless of the unit's deployment status. This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units, AC/RC prior to deploying to a theater of operation. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deploying and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can tailor their training, both pre-deployment/pre-mobilization, as well as during deployment/mobilization, to this mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

Chapter 9
Question f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records[1] and the medical reporting of detainee abuse?

Section I
Operation Enduring Freedom

9-1. Findings

a. For RC past/present OEF interviewees, no or minimal unit training was conducted on detainee medical records at the home station, during mobilization, or in theater. No future RC OEF deployers were interviewed.

b. For RC past/present OEF interviewees, less than one-quarter received unit training on detainee medical records at the home station, during mobilization, or in theater. No future RC OEF deployers were interviewed.

c. None of the interviewees were aware they were deploying to a detainee mission in theater prior to deployment.

9-2. Discussion

a. *Training on Detainee Medical Records:*

(1) 37 RC past/present OEF medical personnel were interviewed:

(a) 0% reported receiving unit training at home station (Question 70).

(b) 3% reported receiving unit training during mobilization (Question 71).

(c) 7% reported receiving unit training in theater (Question 72).

(2) No future deploying RC units were interviewed.

b. *Training on Detainee Abuse Reporting:*

(1) 38 RC past/present OEF medical personnel were interviewed:

(a) 5% reported receiving unit training at home station (Question 52).

(b) 21% reported receiving unit training during mobilization (Question 53).

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[1] As noted in paragraph 6-2a, 1.2% of 39 RC interviewees surveyed (past and present) and 0% of 37 (future) reported receiving MOS or other school training on detainee medical records.

(c) 16% reported receiving unit training in theater (Question 54).

(2) No future deploying RC units were interviewed.

Section II
Guantanamo Bay Detention Facility

9-3. Findings

Training on detainee medicals records and reporting detainee abuse was received by the two RC past/present GTMO personnel interviewed. No RC future GTMO personnel were interviewed.

9-4. Discussion

a. *Training on Detainee Medical Records.* Only two RC past/present GTMO personnel were interviewed. Both received unit training on detainee medical records at home station, during mobilization, and in theater. No RC future GTMO personnel were interviewed.

b. *Training on Detainee Abuse Reporting.* Only two RC past/present GTMO personnel were interviewed. Both received unit training on reporting detainee abuse at home station, during mobilization, and in theater. No RC future GTMO personnel were interviewed.

Section III
Operation Iraqi Freedom

9-5. Findings

a. For RC past/present OIF interviewees, no or minimal unit training was conducted on detainee medical records at the home station or during mobilization; however, 40% received the training in theater. Only 3% of RC future OIF deployers received the training at their home unit.

b. For RC past/present OIF interviewees, approximately one-quarter received unit training on detainee medical records at the home station, during mobilization, or in theater. Only 13% of RC future OIF deployers received the training at their home unit.

c. No interviewees stated they had prior knowledge of going into theater to perform a detainee-specific mission.

9-6. Discussion

a. *Training on Detainee Medical Records*

(1) 112 RC past present OIF medical personnel were interviewed:

(a) 4% reported receiving unit training at home station (Question 70).

(b) 7% reported receiving unit training during mobilization (Question 71).

(c) 40% reported receiving unit training in theater (Question 72).

(2) Of 38 RC future OIF deploying personnel interviewed, 3% stated they received unit training at their home station on detainee medical records (Question 70).

b. *Training on Detainee Abuse Reporting*:

(1) 112 RC past present OIF medical personnel were interviewed:

(a) 15% reported receiving unit training at home station (Question 52).

(b) 27% reported receiving unit training during mobilization (Question 53).

(c) 27% reported receiving unit training in theater (Question 54).

(2) Of 39 RC future OIF deploying personnel interviewed, 13% stated they received unit training at their home station on reporting detainee abuse (Question 52).

Section IV
Overall Recommendations

9-7. Overall Recommendations

a. Leaders at all levels should conduct meaningful training, and verify by following up with an assessment via a competency test, regardless of the unit's deployment status. This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units prior to deploying to a theater of operations. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deployed and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can then tailor their training, both pre-

deployment/pre-mobilizations as well as during deployment/mobilization, to this unique mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

Chapter 10
Question g. Identify OEF and OIF Detention Medical Facilities

10-1. Background

a. In OIF and OEF, nearly all maneuver and MP units of any size participated to some extent in detainee operations. Participation depended on the type and size of the unit and included:

(1) Point of Capture/Collection Point.

(2) Brigade Internment Facility (BIF).

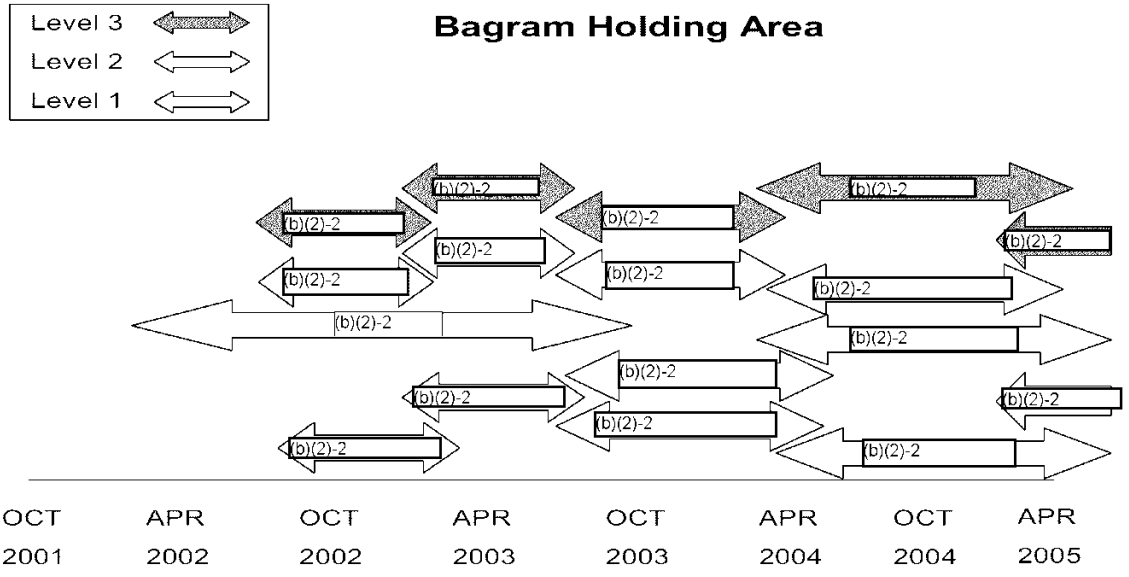
(3) Division Internment Facility (DIF).

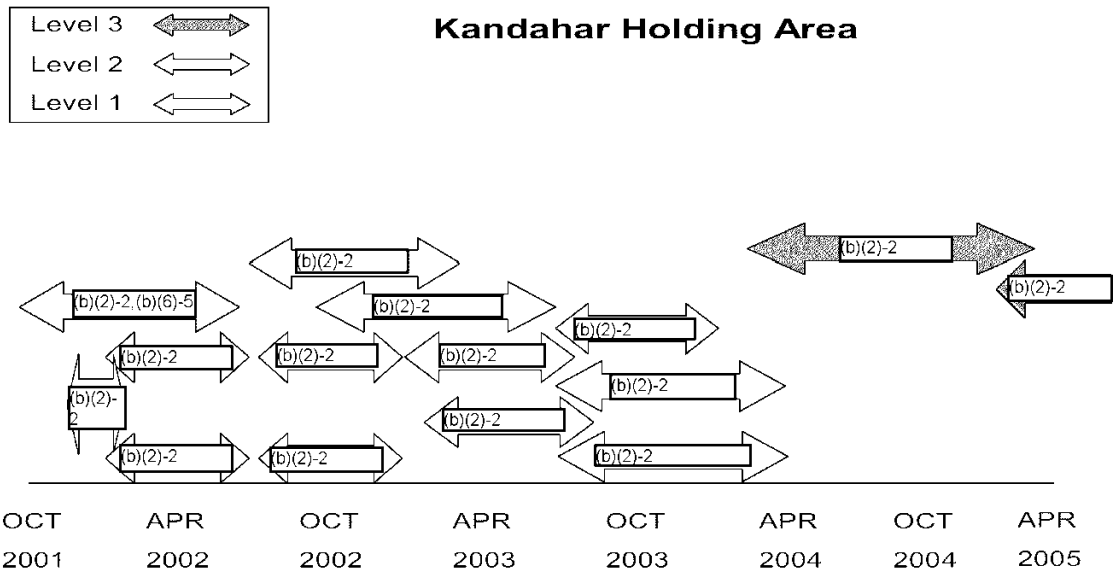
(4) Prison.

b. Medical personnel assigned to these units participated in detainee medical care along a continuum of care ranging from medical screening to acute trauma management and evacuation.

c. At the maneuver Bn and Bde detainee holding facilities the duration of detention ranged from a few hours to several days. The involvement of medical personnel at these locations varied accordingly.

10-2. Operation Enduring Freedom. There are two major detention facilities in Afghanistan, one each at Bagram and Kandahar. The diagrams in this chapter include medical and non-medical units that provided or are currently providing level I, II and III medical care for the detainees at these facilities.





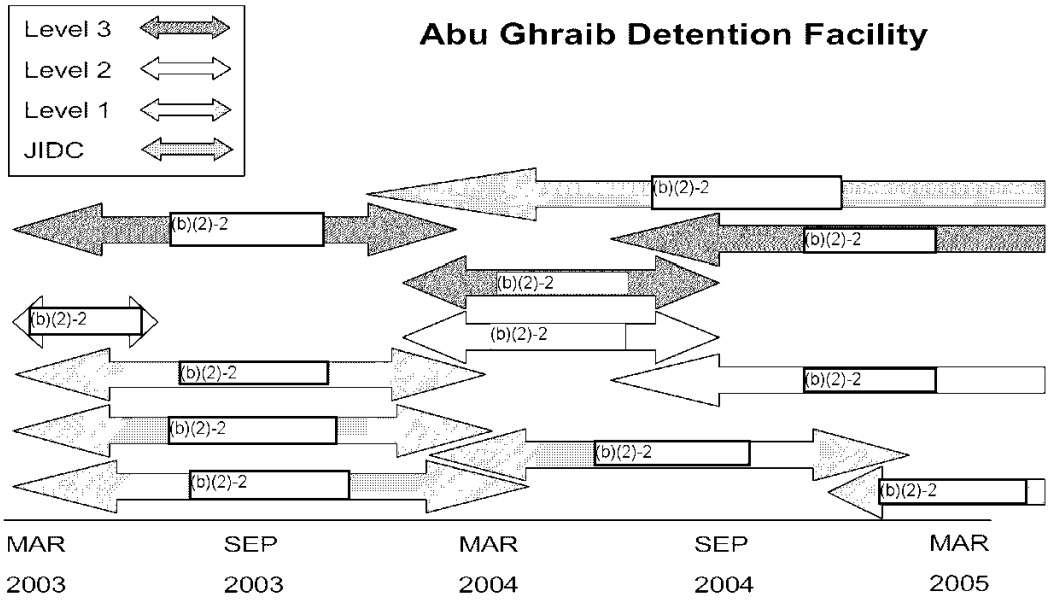
10-3. Guantanamo Bay Detention Facility. There is a dedicated detainee hospital capable of providing level I, II and III care and a base Naval Hospital. The base hospital has a dedicated large 4-bed room available for detainees, capable of supporting critical care needs. Staffing is Tri-service.

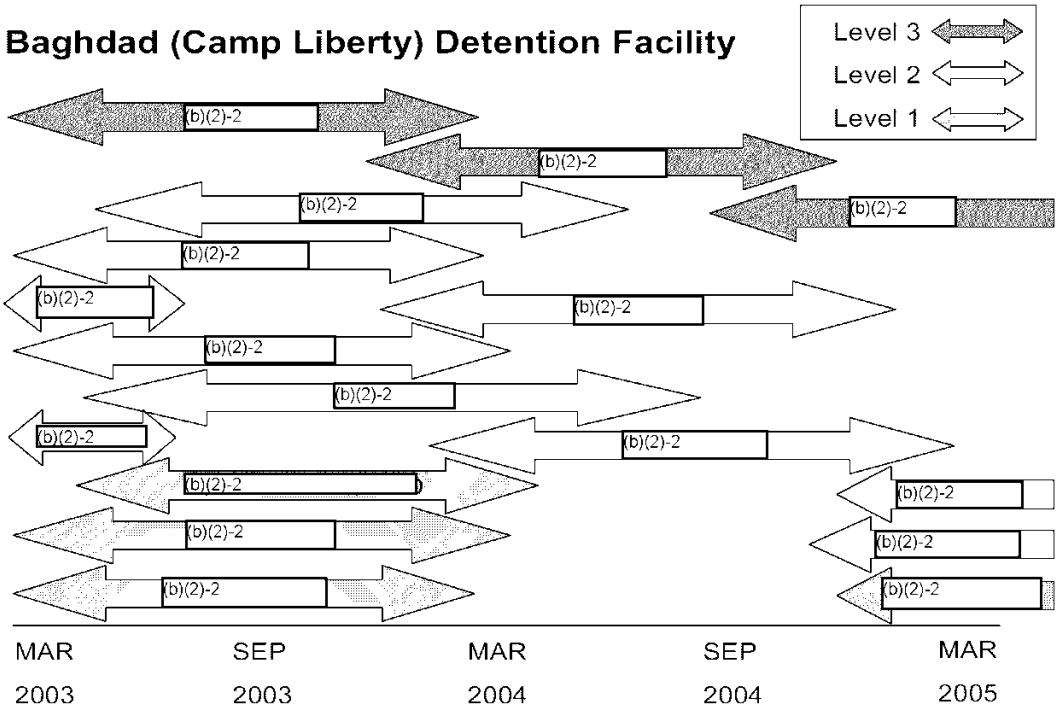
10-4. Operation Iraqi Freedom.

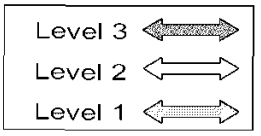
a. There are three prisons in Iraq: Camp Cropper (also known as Baghdad International Airport (BIAP) or High Value Detainee (HVD) detention facility), Abu Ghraib, and Camp Bucca. There are also three division level internment facilities in Iraq at Baghdad, Mosul, and Tikrit. The diagrams in this chapter include medical and non-medical units that provided or are currently providing level I, II and III medical care for the detainees.

b. In January 2004, (b)(2)-2 Med Bde (followed by (b)(2)-2 Med Bde in February 2004) established TF Oasis to provide level II and III medical care for Abu Ghraib. The soldiers comprising this task force were from the following units: (b)(2)-2 (b)(2)-2 (b)(2)-2 This was the first "detainee-only" hospital built by the Army. It opened for inpatient occupancy on 18 March 2004.

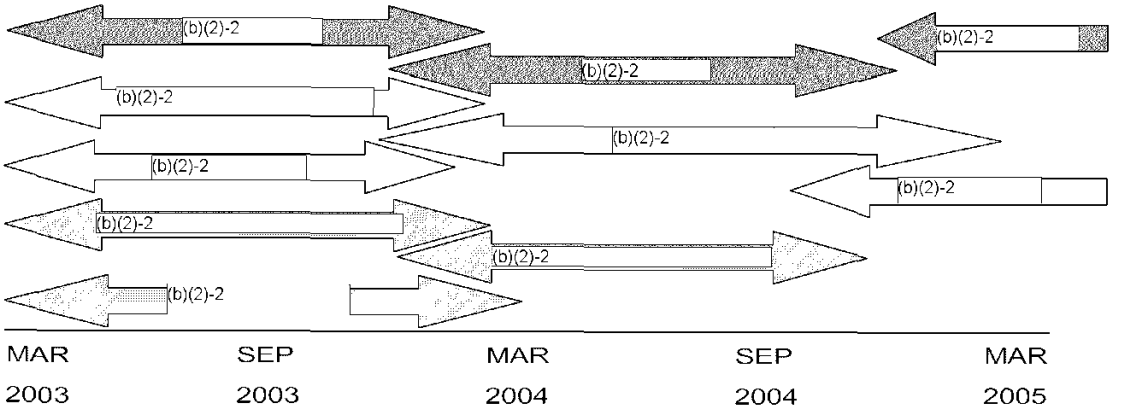
c. In August 2004, (b)(2)-2 deployed to Abu Ghraib to further expand medical capabilities for detainees for level III and ultimately limited rehabilitative medical care. In October 2004, a slice of (b)(2)-2 (including medical personnel from the (b)(2)-2 (b)(2)-2 moved to Camp Bucca to establish level III care at that detention facility.

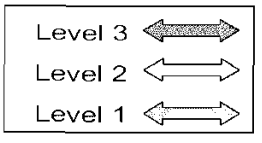

Level 3
Level 2
Level 1
JIDC
Abu Ghraib Detention Facility
(b)(2)-2
MAR 2003
SEP 2003
MAR 2004
SEP 2004
MAR 2005


Baghdad (Camp Liberty) Detention Facility
Level 3
Level 2
Level 1
(b)(2)-2
MAR 2003
SEP 2003
MAR 2004
SEP 2004
MAR 2005

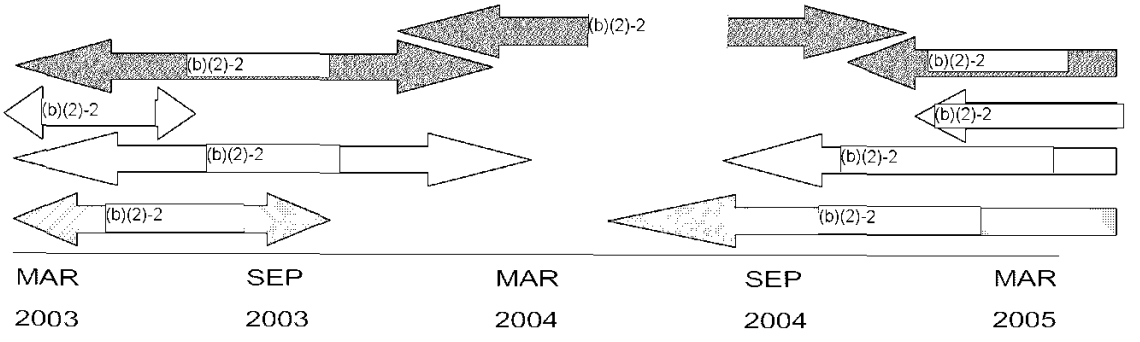


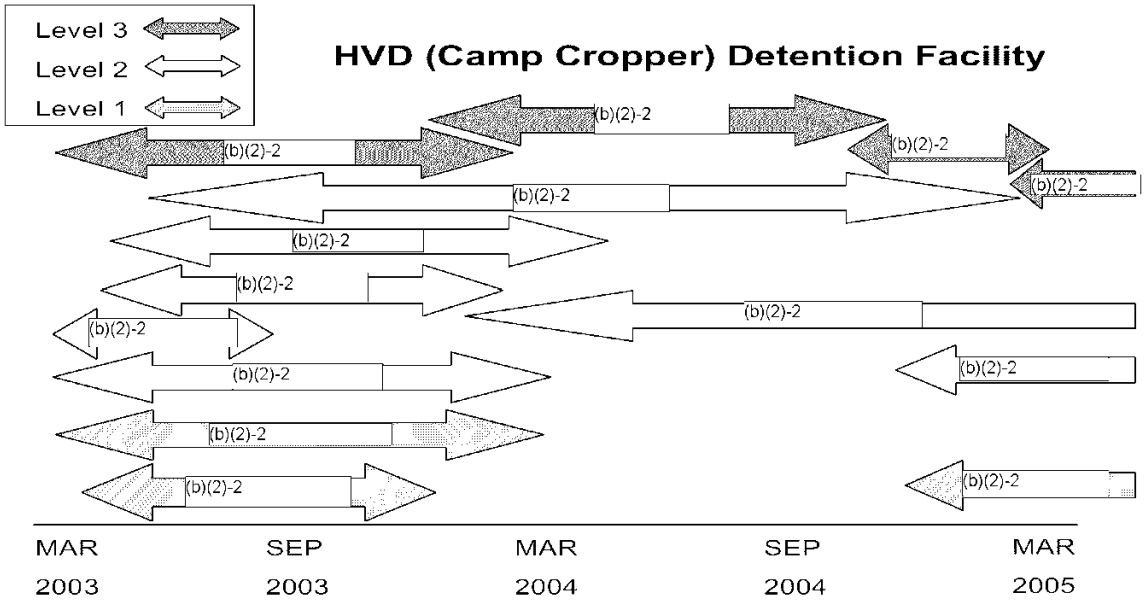
Mosul Detention Facility

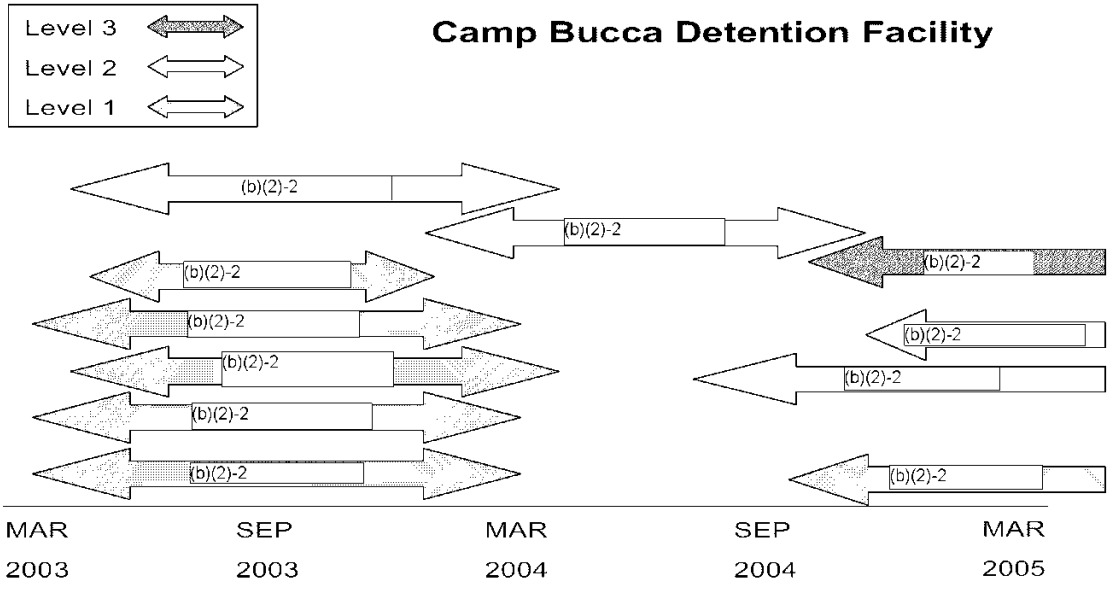




Tikrit (Camp Danger) Detention Facility




Level 3
Level 2
Level 1
HVD (Camp Cropper) Detention Facility
(b)(2)-2
MAR 2003
SEP 2003
MAR 2004
SEP 2004
MAR 2005


Level 3
Level 2
Level 1
Camp Bucca Detention Facility
(b)(2)-2
MAR 2003
SEP 2003
MAR 2004
SEP 2004
MAR 2005

Chapter 11
Question h. With respect to the detention medical facilities identified in subparagraph g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.

11-1. Findings

a. Guidance regarding criteria for pre- and post-interrogation medical screening is inconsistent.

b. Medical care (including screenings) at or near the time of interrogations was neither consistently documented nor consistently included in detainee medical records.

c. Some medical personnel were unclear whether interrogations could be continued if a detainee required medical care during the interrogation.

d. Medical personnel at some locations felt empowered to halt interrogations for either medical or safety reasons.

11-2. Discussion

a. *Operation Enduring Freedom*

(1) No interviewees reported being asked to provide medical care during interrogations so that the interrogations could be continued. No interviewees reported being aware of other medical personnel who were asked to do the same.

(2) 38% (3 of 8) of interviewees who served at Bagram reported that pre-interrogation screenings were completed. 25% (2 of 8) reported that post-interrogation screenings were completed. Those giving positive responses agreed that this information was always documented, but was not always included in the medical records.

(3) 33% (3 of 9) of interviewees who served at Kandahar reported that pre-interrogation screenings were completed. 11% (1 of 9) reported that post-interrogation screenings were completed. Those giving positive responses agreed that this information was always documented and was always included in the medical records.

b. *Guantanamo Bay Detention Facility*

(1) No interviewees were asked to provide medical care during interrogations so that the interrogations could be continued. No interviewees were aware of other medical personnel who were asked to do the same.

(2) No interviewees reported either pre or post interrogation screenings were completed.

c. *Operation Iraqi Freedom*

(1) 1% (7 of 483) of interviewees were asked to provide medical care to detainees during interrogations so that the interrogations could be continued. These seven individuals represent seven different units, and each individual was requested to do so only once.

(2) All seven reported administering the medical treatment that was required. Examples include (a) intravenous fluid administration for symptoms consistent with or for actual volume depletion and (b) providing food for hypoglycemia. One occurred at Camp Cropper in 2003 and one occurred at Abu Ghraib in 2003, while the other five occurred at short-term holding areas or collection points at various times. (See Interview #s 517, 698, 132, 661, 60, 250, and 505.)

(3) *Abu Ghraib*

(a) Prior to January 2004, very few pre- or post-interrogation screenings were completed at Abu Ghraib. In January 2004, the Air Force Detainee Health Team (DHT) was tasked to support military interrogation operations; the team consisted of one Family Medicine or Internal Medicine physician, one PA, and two medics.

(b) The DHT provided initial medical assessments of detainees to determine preexisting conditions that might affect the interrogation process; it was also tasked with completing pre-, trans-, and post-interrogation medical assessments on an individual basis, at the request of the interrogators. These medical assessments were documented on a SF600 and included in detainee medical records. (See CONOPS for DHT in Support of Military Intelligence Interrogation Operations (Cit. 18).)

(c) All interviewed DHT members denied ever being asked to provide medical care to detainees during interrogations so that the interrogations could continue. If medical care was needed for detainees during an interrogation, the interrogation was stopped, treatment was rendered, and the interrogation did not continue. (See Interview # 734, 788, 817.)

(4) *Camp Bucca.* 12% (3 of 25) of interviewees reported that pre- and post-interrogation screenings were completed. Of these 3, 2 (8% of total) reported that screenings were documented and included in the medical records.

(5) *Camp Cropper.* 49% (19 of 39) of interviewees reported that pre-interrogation screenings were completed. Of these 19, 17 (44% of total) reported screenings were documented, and of these 17 individuals, 9 (23% of total) reported documentation was included in the medical records. 10% (4 of 39) of interviewees reported that post-

interrogation screenings were completed, documented, and included in the medical records.

(6) *Camp Liberty*. 48% (19 of 40) of interviewees reported that pre-interrogation screenings were completed. Of these 19, 18 (45% of total) reported screenings were documented, and of these 18 individuals, 10 (25% of total) reported documentation was included in the medical records. 15% (6 of 40) of interviewees reported that post-interrogation screenings were completed, documented, and included in the medical records.

(7) *Mosul.* 17% (1 of 6) of interviewees reported that pre-interrogation screenings were completed and documented; however, the individual was unsure if documentation was included in the detainee medical records. No interviewees reported that post-interrogation screenings were completed.

(8) *Tikrit.* 14% (1 of 7) of interviewees reported that pre-interrogation screenings were completed, documented, and included in the detainee medical records. No interviewees reported that post-interrogation screenings were completed.

11-3. Recommendations. DA guidance (DOD level is preferable) should:

a. Authorize medical personnel to halt any interrogation or interrogation technique if the detainee's health or welfare is endangered.

b. Require interrogations to stop immediately if a detainee requires any medical treatment during the interrogation.

c. Authorize medical personnel to perform pre- and/or post-interrogation medical evaluations at their discretion.

d. Require pre- and/or post- interrogation medical evaluations be performed upon the request of an interrogator.

e. Require all pre-, during, and post-interrogation medical care to be documented and included in the detainee medical records.

f. Describe the process for documenting medical care delivered during or due to an interrogation.

g. Describe the process to report and document in the medical record suspected abuse.

h. Require medical personnel to be trained on the above recommendations, with follow-up assessment of competency to measure the effectiveness of training.

Chapter 12
Question i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?

Section I
General Findings

12-1. General Findings

a. Level III facilities consistently generated detainee medical records in the same manner as records for U.S. patients.

b. The final disposition of original detainee medical records from level III facilities was usually the same as that of "retired" U.S. medical records (sent to PASBA).

c. Within and among all interviewees from units providing level I and II medical care, there was extreme variability in method of documentation, circumstances influencing the creation of documentation, and the maintenance and final disposition of detainee medical records.

d. In two separate instances, individuals reported reservations about writing their names on medical records that might eventually be given back to the detainee. One provider in OEF omitted his name entirely, and one provider in OIF intentionally changed the spelling of his last name.

Section II
Operation Enduring Freedom

12-2. Findings

a. The Team interviewed five PAD personnel (MOS 70B, 70E, and 91G) from four hospitals (b)(2)-2 which provided or are currently providing level III detainee care in Bagram and Kandahar. All indicated that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD until the records were forwarded to PASBA for storage.

b. Interviewees from the (b)(2)-2 reported copies of medical records were exclusively made to accompany detainees being transferred to another detention facility (e.g., GTMO). The (b)(2)-2 made no copies of detainee medical records.

c. At Bagram, 85% (41 of 48) of interviewees reported unit procedures for controlling access to detainee medical records and 78% (36 of 46) reported unit procedures for

maintaining security of these records. None of 46 said that either "anyone" or interrogators could have access to these records.

d. At Kandahar, 73% (11 of 15) of interviewees reported unit procedures for controlling access to detainee medical records and 75% (12 of 16) reported unit procedures for maintaining security of records. None of the 16 said "anyone" could have access to these records and only 6% (1 of 16) said interrogators could have access.

Section III
Guantanamo Bay Detention Facility

12-3. Findings

a. No specific PAD personnel were formally interviewed; however, during the site visit, the Team observed that detainee medical records were generated and maintained in the same manner as records of U.S. patients. The original medical records are maintained by PAD.

b. All nine interviewees reported unit procedures for controlling access to detainee medical records and unit procedures for maintaining security of these records. One of nine (11%) reported that "anyone" could have access to these records. (This individual then stated that no interrogators could have access.)

Section IV
Operation Iraqi Freedom

12-4. Findings

a. *Abu Ghraib and Camp Cropper*

(1) The Team interviewed two PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 that provided or are currently providing level III detainee care at Abu Ghraib and Camp Cropper. Both reported that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD until the records were forwarded to PASBA for storage.

(2) The (b)(2)-2 sent copies of discharge summaries to detention medical facilities. The (b)(2)-2 makes copies of detainee medical records only for CID, as needed for evidence in investigations.

(3) At Abu Ghraib, 73% (107 of 147) of interviewees reported unit procedures for controlling access to detainee medical records, and 70% (103 of 147) reported unit procedures for maintaining security of these records. 6% (9 of 147) said "anyone" could have access to these records and 7% (10 of 147) said interrogators could have access.

(4) At Camp Cropper, 69% (124 of 181) of interviewees reported unit procedures for controlling access to detainee medical records and unit procedures for maintaining security of these records. 6% (11 of 181) said "anyone" could have access to records and 7% (12 of 181) said interrogators could have access.

b. *Camp Bucca*

(1) The Team interviewed one 91G from the (b)(2)-2 which is currently providing level III detainee care at Camp Bucca. He reported that detainee medical records are generated and maintained in the same manner as records of U.S. patients in theater. The original medical records are maintained by PAD initially and are then apparently provided to the detainee. Copies of detainee medical records are only made for CID as needed for evidence in investigations.

(2) 63% (24 of 38) reported unit procedures for controlling access to detainee medical records and 58% (22 of 38) reported unit procedures for maintaining security of these records. 3% (1 of 38) said either "anyone" or interrogators could have access to these records.

c. *Camp Liberty*

(1) The Team interviewed three PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 that provided or are currently providing level III care for detainees at the DIF at Camp Liberty. All indicated that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records in both facilities were initially maintained by PAD and then forwarded to PASBA.

(2) The (b)(2)-2 sent copies of discharge summaries to the detention medical facility. The (b)(2)-2 makes copies of detainee medical records only for CID, as needed for evidence in investigations.

(3) 65% (124 of 190) reported unit procedures for controlling access to detainee medical records and 66% (125 of 190) reported unit procedures for maintaining security of these records. 7% (12 of 190) said "anyone" could have access to these records and 9% (16 of 190) said interrogators could have access.

d. *Mosul*

(1) The Team interviewed four PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 which provided level III care for detainees at the DIF in Mosul. All reported that detainee medical records were generated and maintained in the same manner as records for U.S. patients in theater.

(2) At the (b)(2)-2 the original medical records were initially maintained by PAD and then forwarded to PASBA for storage.

(3) The (b)(2)-2 records are being maintained by their PAD permanently. These records have not been forwarded to a repository. Copies of detainee medical records were sent to the detention medical facilities, to civilian hospitals, or other MTFs whenever detainees were transferred to one of these locations.

(4) 78% (60 of 77) reported unit procedures for controlling access to detainee medical records and 77% (59 of 77) reported unit procedures for maintaining security of these records. 4% (3 of 77) said "anyone" or interrogators could have access to these records.

e. *Tikrit*

(1) The Team interviewed one 91G from the (b)(2)-2 which provided level III care for detainees at the DIF in Tikrit. He reported that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD and then forwarded to PASBA. Copies of detainee medical records were sent with detainees to the DIF upon discharge.

(2) 79% (45 of 57) reported unit procedures for controlling access to detainee medical records and 81% (46 of 57) reported unit procedures for maintaining security of these records. 5% (3 of 57) said "anyone" could have access to these records and 4% (2 of 57) said interrogators could have access.

Section V
General Discussion

12-5. Methods of documentation for level I and II care include the following practices

a. Completing an initial detainee medical evaluation on a Field Medical Card (FMC) (Department of Defense Form 1380 (DD1380)) only, but then no subsequent documentation of any detainee care.

b. Documenting detainee care in a log book for statistical purposes and unit reports.

c. Documenting detainee care on Standard Form 600 (SF600) (Chronological Record of Medical Care) only for detainees with chronic medical conditions (with no documentation for others).

d. Documenting all detainee care on SF600's, but not documenting the initial screenings.

e. Documenting initial screenings for all detainees on overprinted SF600's.

f. Documenting a complete history and physical examination on some or all detainees using the SF88 (Report of Medical Examination) and SF93 (Report of Medical History).

12-6. Locations where original detainee medical documents were stored for level I and II care include the following:

a. Detention facilities.

b. Detention medical facilities.

c. Medical unit treatment areas.

d. Interrogation records maintained by MI/MP personnel.

12-7. Copy machines. Copy machine availability was variable; therefore, when detainees were transferred to other detention facilities or medical facilities, they were accompanied by original medical records, copies of records, or sometimes no records at all.

12-8. Access to and Security of Detainee Medical Records. The Team addressed access to and security of detainee medical records with several specific interview questions in addition to direct observations and questions during site visits to OEF, GTMO, and OIF. Individual responses to the pertinent questions were generally very consistent within each location, as well as across OEF, GTMO, and OIF.

a. Security of records and confidentiality of medical information tended to be better at detention facilities that were co-located with medical facilities. Security and confidentiality also generally improved as an individual theater matured.

b. When asked about which "other" personnel could have access to detainee medical records besides the treating medical personnel, the vast majority of answers were: PAD, CID, ICRC, and medical chain of command. A few individuals included MPs or other detention facility personnel.

Section VI
General Recommendations

12-9. DA guidance (DoD level is preferable) should:

a. Require that detainee medical records at facilities that deliver level III and higher care be generated in the same manner as records of U.S. patients in theater.

b. Address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care.

c. Define appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

d. Address the need for uniform documentation, to include accurate identification of all individuals entering information into all detainee medical records.

e. Clearly outline the rules for access to detainee medical records and provision of medical information to non-health care providers. The guidance should only permit release of detainee medical information to interrogators when needed to ensure the health and welfare of the detainee.

12-10. Training of medical personnel. All medical personnel should be trained on the above and evaluated for competency.

12-11. DA guidance (DoD level is preferable) should:

a. Define who has access to detainee medical information and under what circumstances.

b. Require that all military personnel are trained on this policy and evaluated for competency.

Chapter 13
Question j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.

See Chapter 12 (Question i).

Chapter 14
Question k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?

14-1. General Findings

a. Medical personnel were aware of, and treated injuries related to, actual and suspected detainee abuse.

b. 5.0% (30 of 596) of past OEF/GTMO/OEF interviewees directly observed actual or suspected detainee abuse.

c. 3.1% (2 of 64) of present OEF/GTMO/OIF interviewees directly observed actual or suspected detainee abuse.

d. 5.4% (43 of 798) of past OEF/GTMO/OEF interviewees had a detainee directly report alleged abuse to them.

e. 26.3% (20 of 76) of present OEF/GTMO/OIF interviewees had a detainee directly report alleged abuse to them.

14-2. Findings - Operation Enduring Freedom

a. No (0 of 60) past OEF interviewees directly observed actual or suspected detainee abuse.

b. No (0 of 11) present OEF deployed interviewees directly observed actual or suspected detainee abuse.

c. 1.6% (1 of 63) of past OEF interviewees had a detainee directly report alleged abuse to them.

d. No (0 of 14) present OEF interviewees had a detainee directly report alleged abuse to them.

14-3. Findings - Guantanamo Bay Detention Facility

a. No (0 of 2) past GTMO Interviewees directly observed actual or suspected detainee abuse.

b. No (0 of 7) of present GTMO interviewees directly observed actual or suspected detainee abuse.

c. No (0 of 2) of past GTMO interviewees had a detainee directly report alleged abuse to them.

d. 28.6% (2 of 7) of present GTMO interviewees had a detainee directly report alleged abuse to them.

14-4. Findings - Operation Iraqi Freedom

a. 5.0% (30 of 596) of past OIF interviewees directly observed actual or suspected detainee abuse.

b. 3.1% (2 of 64) of present OIF interviewees directly observed actual or suspected detainee abuse.

c. 5.4% (42 of 733) of past OIF interviewees had a detainee directly report alleged abuse to them.

d. 32.7% (18 of 55) of present OIF interviewees had a detainee directly report alleged abuse to them.

14-5. General Discussion

a. The above findings are based on responses to two questions:

(1) *Question 141* – Did any detainee report abuse directly to you?

(2) *Question 145* - Did you directly (or personally) observe detainee abuse?

b. Medical personnel are often in a position to observe the physical evidence of actual or suspected abuse. Alleged abuse can also be revealed when obtaining a detainee's medical history. Not all acts of abuse are evidenced by physical injuries.

c. Two important assumptions overlay the above findings.

(1) Injuries potentially consistent with abuse can occur as a result of lawful combat operations (including the forcible capture of enemy combatants).

(2) Lawful physical force is sometimes required to maintain good order and discipline in a detention setting.

f. Acts of torture are clearly detainee abuse; however, other acts below the internationally recognized threshold of torture violate the standards of AR 190-8. The language of AR 190-8 sets a high standard of care and concern for all detainees:

(1) Paragraph 1-5a(1): "All persons captured, detained, interned, or otherwise held in U.S. Armed Forces custody during the course of conflict will be given humanitarian care and treatment from the moment they fall into the hands of U.S. forces until final release or repatriation."

(2) Paragraph 1-5a(2): "As a matter of policy, all detainees will be treated in accordance with the principles applicable to enemy prisoners of war unless and until a more precise legal status and accordant treatment is determined appropriate by competent authority."

(3) Paragraph 1-5b: "The following acts are prohibited: murder, torture, corporal punishment, mutilation, the taking of hostages, sensory deprivation, collective punishments, execution without trial by proper authority, and all cruel and degrading treatment."

(4) Paragraph 1-5c: "All persons will be respected as human beings. They will be protected against all acts of violence to include rape, forced prostitution, assault and theft, insults, public curiosity, bodily injury, and reprisals of any kind. This list is not exclusive. EPW/RP are to be protected from all threats or acts of violence."

14-6. General Recommendations

a. A DA definition of detainee abuse should be adopted (a DoD definition is preferable).[1]

b. At all levels of professional training medical personnel should receive instruction on the definition of detainee abuse and the requirement to document and report actual or suspected detainee abuse.

c. Pocket cards be developed and distributed to all deploying medical personnel with "Medical Rules of Engagement" on the front and a training aid on detainee abuse on the back.[2]

[1] The prohibitions of Paragraphs 1-5a through 1-5c of AR 190-8 should be considered when developing a definition for "detainee abuse."

[2] Two suggested recommendations are below:

	The ABCs of Detainee Abuse		**Be a Medic**
A	Abuse is always wrong	**M**	Medically asses all detainees
B	Be aware of the signs of abuse	**E**	Examine detainees for signs of abuse
C	Convey suspected abuse to your chain of command	**D**	Document your findings
		I	Inform your chain of command of suspected abuse
		C	Chart your actions

Chapter 15
Question I. Did any medical personnel aware of, or who treated actual or suspected detainee abuse, properly document the abuse?

15-1. Findings

a. Although the majority of medical personnel aware of actual or suspected abuse reported the abuse to proper authorities, they did not consistently nor uniformly document such abuse in the medical record.

b. The documentation of abuse in detainee medical records by medical personnel falls into three categories:

(1) Medical personnel who routinely documented actual or suspected abuse and noted they had reported the abuse.

(2) Medical personnel who routinely documented actual or suspected abuse but failed to note in the medical record if they had reported the abuse.

(3) Medical personnel who failed to document actual or suspected abuse (medical evidence of abuse but no further notations in the medical record or lack of medical record).

c. The Team discovered no DoD, Army, or theater policies requiring that actual or suspected abuse be documented in a detainee's medical records.

15-2. Discussion

a. Team members reviewed 463 detainee CSH medical records from OEF, GTMO, and OIF. Thirty-four (7.3%) of the reviewed records contained medical evidence of suspected abuse or notations of alleged abuse. Twenty-four of the 34 (70.6%) records do not state what action was taken concerning the suspected or alleged abuse.

b. The first opportunity for medical personnel to document alleged or suspected abuse is often during a detainee's initial medical screening. There is no standardized detainee medical screening form.[1] The Team reviewed several field medical screening forms. All were different.

c. Effective communication to subordinate units remains especially challenging in a deployed theater. One example highlights this point. The Commander, (b)(2)-2 distributed AR 190-8 via e-mail to subordinate units. Some units providing detainee care reported never receiving this information. Many interviewees across the spectrum

[1] DA Form 4237-R (Detainee Personnel Record), found at page 81 in AR 190-8, contains one section (paragraph 44) entitled "Medical Record." The Team considers the required information in this section to be inadequate.

of units the Team visited (including at least one Division Surgeon) were unaware of the medical guidance contained in AR 190-8.

15-3. Recommendations

a. A DA definition of detainee abuse be adopted (a DoD level definition is preferable).

b. A DA standard requiring actual, alleged or suspected abuse be documented in a detainee's medical record (a DoD level standard is preferable). The standard should require:

(1) Documentation of actual, alleged or suspected abuse in the detainee's medical record.

(2) The medical provider's opinion if the medical evidence supports actual, alleged or suspected abuse; and

(3) The action taken by medical personnel:

(a) If the medical evidence fails to support the alleged abuse this fact should be noted in the detainee's medical record.

(b) If the medical evidence is consistent with abuse, or is inconclusive, medical personnel must report the alleged or suspected abuse to the hospital/MTF commander (MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 04) (Cit. 31).

(c) A notation in the detainee's medical record that a report was made, when, and to whom.

c. A DA standard detainee medical screening form should be developed and fielded (a DoD level standard is preferable).

Chapter 16
Question m. To whom did any medical personnel aware of, or who treated, detainee abuse report such abuse?

16-1. General Findings

a. Medical personnel aggressively reported actual and suspected detainee abuse to the proper authorities.[1]

b. Medical personnel typically reported actual or suspected detainee abuse to one (or more) of three channels:

(1) Medical supervisor.

(2) Chain of command.

(3) Criminal investigators (CID).

c. 73 previously deployed medical personnel were personally aware of actual or suspected abuse.[2] 87.6% (64 of 73) reported the actual or suspected abuse.[3]

d. 22 presently deployed medical personnel were personally aware of actual or suspected abuse.[4] 100% (22 of 22) reported the actual or suspected abuse.

e. Only 2 interviewees failed to properly report actual or suspected detainee abuse which had not otherwise been conveyed to an appropriate authority.[5]

16-2. Findings - Operation Enduring Freedom

a. 1 previously deployed OEF medical provider was personally aware of actual or suspected abuse. This provider reported the actual or suspected abuse.

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[1] An incident of abuse may have been observed and/or reported by more than one interviewee.

[2] 5.4% (43 of 798) of past OEF/GTMO/OIF interviewees responded "yes" to question 141 (Did any detainees report abuse directly to you?). 5.0% (30 of 596) of past OEF/GTMO/OIF interviewees responded "yes" to question 145 (Did you directly observe possible abuse?).

[3] There were 4 "no report made" answers to question 142 by previously deployed personnel. One was not reported for lack of specific information (Interview 140). Three were deemed to lack credibility (Interviews 415, 454 and 945). There were 5 "no report made" responses to question 146. In three cases the interviewees reported action was taken (Interviews 465, 717 and 729).

[4] 26.3% (20 of 76) of present OEF/GTMO/OIF interviewees responded "yes" to question 141 (Did any detainees report abuse directly to you?). 3.1% (2 of 64) of present OEF/GTMO/OIF interviewees responded "yes" to question 145 (Did you directly observe possible abuse?).

[5] The Team referred one of these cases to CID (Interview 72) and one to the chain of command after conferring with the CID Staff Judge Advocate (Interview 33). One additional case, in which previous administrative action was taken, was also referred by the Team to CID (See Chapter 20, Incident and Allegations Table #72).

b. No presently deployed OEF medical personnel stated they were personally aware of actual or suspected abuse.

16-3. Findings - Guantanamo Bay Detention Facility

a. No previously deployed GTMO medical personnel were personally aware of actual or suspected abuse.

b. 2 presently deployed GTMO medical personnel were personally aware of actual or suspected abuse. Both stated they reported the actual or suspected abuse.

16-4. Findings - Operation Iraqi Freedom

a. 72 previously deployed OIF medical personnel were personally aware of actual or suspected abuse. 85.5% (63 of 72) reported the actual or suspected abuse (See footnote #3).

b. 18 presently deployed OIF medical personnel were personally aware of actual or suspected abuse. 100% (18 of 18) reported the actual or suspected abuse.

16-5. General Discussion

a. Recent media articles have focused on the alleged torture and abuse of detainees by U.S. military members. DoD guidance clearly requires reporting alleged or suspected torture.[6]

b. Present MEDCOM guidance requires medical personnel to report detainee abuse.[7]

c. The above findings are based on responses to four questions:

(1) *Question 141*: Did any detainee report abuse directly to you?

(2) *Question 142*: (If yes) Did you report this?

(3) *Question 145*: Did you directly (or personally) observe detainee abuse?

(4) *Question 146*: (If yes) Did you report this?

d. By any measure, medical personnel were exceptionally vigilant in reporting actual or suspected detainee abuse. It is especially encouraging that all observed or reported suspicion of detainee abuse was reported by presently deployed medical personnel.

[6] Paragraph 4b, CJCSI 3290.01A, 15 October 2000, Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel (EPW/Detainee Policy) (Cit. 16). Paragraphs 4.3 and 4.4, DoD Dir. 5100.77, DoD Law of War Program (9 December 1998) (Cit. 23).
[7] Health Care Professional Detainee Abuse Reporting Requirements, dated 8 September 2004 (Cit. 31).

16-6. General Recommendations

a. At all levels of professional training, medical personnel should receive instruction on the requirement to document and report actual or suspected detainee abuse. This training should include the definition and signs of actual or suspected detainee abuse.

b. Scenario-based training on detecting detainee abuse should be developed and fielded at all PPPs, MUICs, and reserve medical training sites. All deploying medical personnel should receive this training prior to arrival in theater.

c. All deploying medical personnel, prior to arrival in theater, should receive refresher training on the requirements and procedures to document and report actual or suspected detainee abuse.

d. All individual and collective training for medical personnel (such as NTC, JRTC, Warfighters, and field training exercises (FTXs)) should include reinforcing training on recognizing and reporting actual or suspected detainee abuse.

e. Follow-on competency evaluations should be incorporated into all training guidance and plans.

Chapter 17
Question n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?

17-1. General Findings

a. Theater level guidance specifically requiring medical personnel to report detainee abuse was implemented within the past year.

b. Unit policies and SOPs/TTPs were sometimes absent and/or not properly disseminated to deployed medical personnel.

c. Medical personnel with knowledge of existing unit policies/SOPs/TTPs overwhelmingly complied with such guidance.

(1) 37.0% (295 of 798) of formerly deployed OEF/GTMO/OIF interviewees were aware of a unit requirement to report suspected detainee abuse. 94.2% (278 of 295) of these interviewees reported their unit followed the policies.

(2) 85.5% (65 of 76) of presently deployed OEF/GTMO/OIF interviewees were aware of such policies. 98.5% (64 of 65) of these interviewees reported their unit followed the policies.

d. The awareness of unit level policies requiring reports of detainee abuse has steadily increased.

17-2. Findings - Operation Enduring Freedom

a. The Team did not discover a theater level policy specifically requiring medical personnel to report detainee abuse.[1]

b. 39.7% (25 of 63) of formerly deployed OEF interviewees were aware of a unit requirement to report suspected detainee abuse. 88% (22 of 25) of these interviewees reported their unit followed the policies.

c. 71.4% (10 of 14) of presently deployed OEF interviewees were aware of such policies. All ten reported their unit followed the policies.

[1] There is presently a theater specific requirement to report alleged or suspected detainee abuse to the chain of command. CJTF-76, Detainee Operations SOP (S), paragraph 5b (U), dated 21 January 2005.

17-3. Findings - Guantanamo Bay Detention Facility

a. The earliest discovered theater policy specifically requiring medical personnel to report detainee abuse is dated 9 August 2004.[2]

b. 100% (2 of 2) of formerly assigned GTMO interviewees were aware of such policies. Both reported their unit followed the policies.

c. 71.4% (5 of 7) of presently assigned GTMO interviewees were aware of such policies. All five reported their unit followed the policies.

17-4. Findings - Operation Iraqi Freedom

a. The earliest discovered theater policy specifically requiring medical personnel to report detainee abuse is dated 12 July 2004.[3] The medical unit presently responsible for Abu Ghraib, (b)(2)-2 has also published a requirement to report alleged or suspected detainee abuse.[4]

b. The OIF Theater Detention Healthcare Policy, paragraph 3B, dated January 2005 (Cit. 37), requires medical personnel to be trained to recognize the signs and symptoms of detainee maltreatment and abuse and to report any reported or suspected abuse.[5]

c. The Team did not discover a theater policy specifically requiring medical personnel to report detainee abuse.[6]

d. 34.7% (268 of 773) of formerly deployed OIF interviewees were aware of a unit requirement to report suspected detainee abuse. 94.8% (254 of 268) of these interviewees reported their unit followed the policies.

e. 90.9% (50 of 55) of presently deployed OIF interviewees were aware of such policies. 98% (49 of 50) reported their unit followed the policies.

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[2] USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba, 9 August 2004. Paragraph 10a states "Medical personnel who gain knowledge of physical or mental ill-treatment of detainees will report this ill-treatment to the appropriate military authority." (Cit. 43).

[3] FRAGO 329, Detention Operations to MNC-I OPORD 04-01 (S), 12 July 2004, Annex C (unnumbered paragraph), *Medical Authority Responsibilities* (U), states (original bolded) "**Any sign of mistreatment will be reported to the Commanding General.**"

[4] Paragraph 5 of The Tenets of Detention Healthcare, dated March 2005 (Cit. 45), states "All allegations or possible signs/symptoms of abuse, torture or maltreatment must be immediately reported to CID and the Detention Ops and medical chains of command regardless of whom or when it occurred."

[5] This paragraph also states "Healthcare providers must be trained in the tenets of the Geneva Conventions, the law of war, standards of medical care, AR 190-8, and other regulations and principles of detainee care." This policy does not identify when the required training should occur, nor who is responsible to provide the training. The policy also does not define what personnel are considered to be "healthcare providers."

[6] There is presently a theater specific requirement to report alleged or suspected detainee abuse to the chain of command. CJTF-76, Detainee Operations SOP (S), paragraph 5b (U), dated 21 January 2005.

17-5. General Discussion

a. Many unit policies were verbally briefed to personnel but never formalized in writing.

b. Commanders and leaders at all levels should present a unified position that detainee abuse is wrong, and that alleged or suspected abuse must be promptly documented, reported, and properly investigated.

c. Despite the small GTMO interview sample, the Team is confident the results are accurate. Policies governing detainee procedures at GTMO were extensive, and based on the Team's personal observations, strictly adhered to.

d. Carefully planned post-training competency assessments are critical to ensure training is effectively equipping medical personnel to successfully recognize, document, and report actual or suspected detainee abuse.

17-6. General Recommendations

a. Clearly written standardized policies for documenting and reporting actual or suspected detainee abuse should exist at all levels of command (DoD, Army, Combatant Command, theater, and individual subordinate units). These policies must then receive command emphasis on a continuing basis.

b. Medical planners at all levels should ensure clearly written standardized guidance is provided to medical personnel. This guidance should list possible indicators of abuse and contain concise instruction on how, and to whom medical personnel should document and report actual or suspected abuse.

c. Develop DA level guidance (DoD level is preferable) on the procedures for processing allegations of abuse not supported by medical evidence. This guidance should contain clear instructions on how medical personnel should properly document allegations of abuse that are not further reported based on lack of medical evidence.

Chapter 18
Other Issues

Section I
Overview of Site Visits to Afghanistan (OEF), Cuba (GTMO), and Iraq (OIF)

18-1. Operation Enduring Freedom

a. The overall level of outpatient and inpatient detainee medical care is extremely high.

b. Living conditions are very good and detainees are treated respectfully.

c. During a walk-through of the (b)(2)-2 the Team reviewed the care of a detainee in the Intermediate Care Ward (ICW). Some entries in his record were not signed by an attending physician. Although this was apparently not a common practice at the hospital, others were also hesitant to put their names on entries, as these documents might eventually be given to detainees upon their release from the facility.

d. The Bagram/Kandahar (BHA/KHA) SOP, dated 8 March 2005 (S), states that medical records will be destroyed after three years from the time of any detainee's release. This does not specifically follow the provisions of AR 40-400, paragraphs 15-2 and 15-8, which require fixed and deployed MTFs to transmit/provide PASBA with the medical records and workload reports. Additionally, PASBA has been designated the interim inpatient record holding/processing facility for records from the deployed level III MTFs, memorandum dated 12 Mar 2004, unsigned (Cit. 32).

e. Policies and procedures were often hard to obtain prior to a unit's arrival in theater. Mobilizing units should have access to these well in advance of arrival.

f. Medical care and initial screening procedures at BHA were streamlined and well-conceived.

18-2. Guantanamo Bay Detention Facility

a. The overall level of outpatient and inpatient detainee medical care is extremely high. Staff has the ability to utilize four beds at the Naval Hospital for detainees as well, which can include Intensive Care Unit (ICU) care. According to the Hospital's Commander the GTMO Naval Hospital recently received full Joint Commission Accreditation for Healthcare Organizations (JCAHO) with no findings.

b. Detainee medical records are extremely complete, and mirror U.S. medical records. Outpatient records examined had complete master problem lists. Inpatient discharge summaries are also translated into native languages for those patients being sent home.

c. Detainee living conditions overall appeared very good.

d. All interrogations are videotaped. Medics randomly observe interrogations and have the ability to halt an interrogation at any point they deem necessary.

18-3. Operation Iraqi Freedom

a. (b)(2)-2 *and Camp Bucca*

(1) Overall the level of medical care was felt to be exceptional.

(2) Entire staff takes responsibilities seriously; mottos include: "Restoring America's Honor," and "Detention Healthcare is a Globally Visible, Strategic-level Mission."

(3) Initial intake assessments are very comprehensive and are appropriately recorded. This includes history and physical, dental, nutritional, chest x-ray, immunizations, and retinal scanning. Master problem lists are very complete. Comprehensive care is also available for more complicated chronic diseases, including a multi-disciplinary team for diabetic patients, prosthesis clinic with physical therapy/occupational therapy, and 24 hour in-patient and out-patient psychiatric care.

(4) Daily sick call is well-organized (average up to 10% of the population on any given day) and ranges from on-site in the camp to the emergency room.

(5) Records security is excellent. The staff is well-versed on keeping medical information separate from MI personnel.

(6) Living conditions appeared very good; all detainees were treated respectfully. Detainee rights and patient rights are clearly posted. All staff are directed to report even minimally-suspected abuses.

(7) BSCT staff is appropriately utilized with carefully-defined roles. They do not provide any clinical care.

(8) There is comprehensive development of policies and medical forms, with generally widespread dissemination and education of all staff. Hospital committees are well-organized, including: executive, credentials, pharmacy and therapeutics, and bioethics.

(9) Strong recommendations from the staff to the Team were to widen detention medical training, e.g., incorporate at JRTC, etc.

b. *DIF Visits at Tikrit and Baghdad*

(1) Medical documentation very good; detainees remain at these locations generally days-to-weeks.

(2) Initial intakes are less comprehensive, but still good, and are documented in records.

(3) Some medics were not well-versed in their understanding of the separation of medical information from MI staff, and it was not clear that access to medical information was as secure as possible.

(4) Some translators used during medical intakes and other clinic visits were also used by MI staff during interrogations, also representing a potential breech in security of medical information. The Team discussed this on-site with the staff, as well as with the (b)(2)-2 Commander as a suggested area for improvement.

(5) Shortages of translators existed for a variety of reasons, including: a lack of qualified personnel who have been cleared to work for Coalition Forces, others would terminate their services because of potential danger to themselves from insurgents, and priority often went to interrogation staffing needs.

(6) There were some concerns over the staffing at the DIFs. Medical assets, in particular 91Ws, were provided no flexibility when assigned to these areas. A loss of one person, for any reason, could hamper their ability to provide adequate care.

18-4. Recommendations

a. CFLCC guidance, regulations, and standards in relation to detainee healthcare, to OEF and OIF theaters, should be standard across the AOR, consistent with DoD guidance, and disseminated to the lowest levels.

b. Prior to the onset of operations, combat or humanitarian, dedicated translators must be embedded within level III healthcare units, for use by medical assets only.

c. OIF medical commanders should ensure medical assets are in place, and have a viable system to replenish them when necessary, at level I or II facilities that have significant detainee contact.

d. To ensure that medical information is protected, translators assisting medical personnel with detainee care should not assist interrogators who question the same detainees.

Section II
OIF Theater Preparation for Detainee Medical Care

18-5. Findings

a. In planning for detainee medical operations there were limited assets allocated to provide support for detainee/EPW medical care. The plan did not encompass medical assets to provide chronic care, definitive care, or rehabilitative care in theater. (FRAGO 1206 to CJTF-7 OPORD 03-036 (Secret) and FRAGO 20 to FORSCOM Deployment Orders in Support of OIF-2 (Secret).)

b. There was a requirement to deliver medical care to detainees in theater.

c. Level I, II, and III medical assets were not resourced to deliver the special needs presented by this population.

18-6. Discussion

a. *Planning / Transfer / Evacuation*

(1) Theater medical asset needs were planned using an expected patient population of injured military and non-hostile civilians.

(2) The robust system for medical evacuation allowed military patients to receive treatment at Landstuhl Regional Medical Center (LRMC) and, if needed, in CONUS in a very rapid fashion. In many cases the time from injury to arrival at LRMC was as short as 36 hours.

(3) For injured non-hostile civilians, transfer to Iraqi civilian medical treatment facilities was limited by the level of care available at those facilities (but not by security and intelligence requirements).

(4) Transfer of detainees out of theater, or to other than U.S. military treatment facilities, was not possible due to international agreements and security and intelligence reasons.

b. *Issues Identified with Detainee Care*

(1) Iraqi civilian and detainee populations have special care needs that are not commonly found in our deployed Soldier population; for example, obstetrics, pediatric and neonatal intensive care, dialysis, airborne communicable diseases, and complex chronic medical conditions. Level III MTFs are not routinely equipped with the personnel, supplies, infrastructure, or medications required to properly care for patients with such conditions.

(2) Interviewees reported shortfalls in a number of areas. Some examples are listed below.

(a) Capacity. The extended stays in level II holding areas, combined with prolonged hospital stays of the detainee population, resulted in limited availability of beds and constrained surge capability.

i. Interviewees reported that detainees with external fixators needed to remain in a level III MTF ICW until the external fixator was no longer required, resulting in a need to expand the inpatient bed capability.

ii. Definitive and rehabilitative burn care requires extremely long hospitalization when burn center transfer is not available.

(b) Medications. Units providing level I and II medical care didn't routinely stock medications needed to treat chronic medical and psychiatric problems.

i. Anti-hypertensive, cardiac, anti-tuberculous, anti-psychotic, and anti-depressive medications were not part of the authorized packing list in a MP company or battalion medical section.

ii. Long-acting insulins were not part of the medical equipment sets (MES) packing list for medical companies in a maneuver unit.

iii. Oxygen (or oxygen concentrating equipment) was not available in sufficient quantity to provide continuous oxygen therapy to detainees that were held for prolonged times in medical company holding areas or aid stations.

c. *Facility Infrastructure*

(1) Negative pressure isolation was not available for holding patients with contagious illnesses.

(2) Level III facilities housed detainees in a variety of ways that impacted the location of medical and security resources. Detainees required both ICU- and ICW-level care within a hospital; these separate wards required two different sets of security resources.

d. *Medical Supplies and Equipment*

(1) Level III facilities did not initially stock pedicle screws for spine surgery. The inability to conduct definitive spine surgery increased the hospital length of stay as patients with spinal injuries faced complicated healing and rehabilitative requirements.

(2) MP medics were not supplied with glucometers.

(3) Medical companies stocked a limited supply of glucose test strips and glucometers. These supplies were insufficient to adequately monitor multiple patients for months at a time.

(4) Initially Level III facilities did not have the required plates and screws to definitively treat maxillofacial injuries.

e. *Mental Health and Psychiatric Care Resources*

(1) This is a broad ranging area that includes suboptimal resourcing at all levels of care. Shortfalls existed in medications, isolation capabilities (infrastructure), psychiatric expertise (anti-psychotic and anti-depressive medication management), and counseling expertise (both the mental health professional and the necessary interpreter).

(2) The detainee population became a hotbed for mental health and psychiatric care needs for several reasons:

(a) Individuals were often taken into custody without their personal medication supply.

(b) Mood disorders are often exacerbated in a detention environment.

18-7. Recommendations.

a. The AMEDD should establish an experienced SME team to:

(1) Comprehensively define the personnel, equipment and supply needs for detainee operations.

(2) Develop a method to ensure a flexible delivery system for these special resources to the appropriate levels of care and for the entire timeline of future military operations.

b. Military planners need to assume that there is a high likelihood for detainee operations in all future conflicts and must allocate resources for detainee medical care in the planning process.

Section III
Medical Screening and Sick Call at the DIFs and Prisons

18-8. Findings

a. Detainees have had excellent access to daily sick call, outpatient, and inpatient medical care.

b. The vast majority of interviewees reported that initial screening medical examinations were performed during in-processing to a DIF or prison.

18-9. Discussion

a. *Operation Enduring Freedom*

(1) Bagram

(a) 71% (5 of 7) interviewees reported that detainees receive initial screening medical examinations. Two interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Bagram in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hours access to an on-call medic.

(2) Kandahar

(a) All interviewees (10) reported that medical personnel completed initial screening medical examinations on detainees.

(b) 90% (9 of 10) interviewees reported detainee access to daily sick call. One interviewee, deployed in theater between August 2003 and May 2004, reported that detainee sick call was not available.

(c) The Team reviewed the KHA SOP (Cit. 17). The SOP requires that all detainees receive an initial screening examination, have access to daily sick call, and 24 hour access to an on-call medic.

b. *GTMO.* The Team visited GTMO in January 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

c. *Operation Iraqi Freedom*

(1) Abu Ghraib

(a) 95% (42 of 44) interviewees reported that detainees receive initial screening medical examinations. Two interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Abu Ghraib in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

(2) Camp Bucca

(a) 76% (16 of 21) interviewees reported that detainees receive initial screening medical examinations. One interviewee, deployed in theater from April 2003 to April 2004, stated detainees did not receive initial medical screenings. Four interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Camp Bucca in March 2005. Detainees receive initial screening examinations, have access to daily sick call, and access to an on-call medic continuously.

(3) Camp Cropper:

(a) 86% (31 of 36) interviewees reported that detainees receive initial screening medical examinations. One interviewee, deployed in theater from April 2003 to April 2004, stated detainees did not receive initial medical screenings. Four interviewees were uncertain (they did not work in the detainee intake area).

(b) All but one interviewee reported that detainees had access to daily sick call. One medic, deployed in theater between April 2003 and April 2004, reported that sick call was not available.

(4) Camp Liberty

(a) 97% (34 of 35) interviewees reported that detainees receive initial screening medical examinations. One interviewee was uncertain (he did not work in the detainee intake area).

(b) 94% (33 of 35) interviewees reported detainee access to daily sick call. One interviewee, deployed in theater between February 2003 and February 2004, stated sick call was not available, one interviewee was uncertain.

(c) The Team visited Camp Liberty in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

(5) Mosul

(a) 88% (7 of 8) interviewees reported detainees receive initial screening medical examinations. The other interviewee was uncertain.

(b) 88% (7 of 8) interviewees reported detainees had access to daily sick call. One interviewee, who was in theater between February 2003 and June 2003, reported that sick call was not available. It is unclear what dates he worked at the detention facility itself.

(6) Tikrit

(a) All five interviewees reported that detainees receive initial screening medical examinations. Detainees presently have access to daily sick call.

(b) The Team visited the facility in Tikrit in March 2005. Detainees receive initial screening examinations, have access to daily sick call, and 24 hour access to an on-call medic.

18-10. Recommendations

a. DA guidance (DoD level is preferable) should require:

(1) Initial medical screening examinations upon inprocessing to a detention facility.

(2) Daily access to medical care for all detainees.

b. All military personnel must be trained on the above policy and demonstrate competency.

Section IV
Restraints/Security

18-11. Findings

a. The use of physical restraints for detainees varied widely within and among all interviewed units.

b. The Team found no evidence that medical personnel used medications to restrain detainees.

c. Interviewees reported medical personnel were tasked to perform a variety of detainee security roles.

d. Medical documentation of restraint was neither uniform nor consistent.

18-12. Discussion

a. The Team found little consistency in the use of restraints for detainees. Some medical units used restraints on all detainees for security reasons, some used them only when detainees were violent or disruptive, and others, specifically level III facilities, used them only for medical indications such as attempts to dislodge medical devices, or for risk of falling.

b. The following factors influenced the decision to restrain detainees.

(1) The availability of MPs.

(2) The availability of unit medical staff for security purposes.

(3) Unit policies and directives.

c. Interviewees expressed concern about tasking of medical personnel for detainee security purposes. The rationale for the concern was the ethical conflict of both caring for and guarding detainees. Additionally, as medical personnel were tasked to provide security support, it impacted on the ability of the unit to provide care to all patients, including U.S. Soldiers.

d. 28% (196 of 728) interviewees reported good or excellent medical documentation related to the use of restraints. The Team found that many medical personnel may not have viewed this as a high priority. Detainee inpatient documentation on the use of restraints was not consistent with restraint documentation standards found in most U.S. hospitals.

18-13. Recommendations

a. DA guidance (DoD level is preferable) should standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraint. Medical personnel must be trained on this guidance, with follow-up competency evaluations.

b. Use of restraints on any patient should be appropriately documented in the medical record.

c. All facilities providing level II or III care should be appropriately supplemented with MPs dedicated to provide detainee security.

Section V
Medical Personnel Photographing Detainees

18-14. Findings

a. There are inconsistencies among ARs, individual unit guidance, and usual medical practices regarding photographing detainees.

b. Many medical personnel photographed detainees for a variety of reasons, including: medical documentation, future teaching material, possible criminal investigation documentation, and future identification for detainee family members.

18-15. Discussion

a. Of the 520 individuals asked, 73% (379) said photographs of detainees were taken in their units with either a personal or unit-owned camera. When pictures were used for documentation, they were included in the detainee medical record(s), included in an investigation record, or obtained post-mortem for future identification, i.e., when no family members were available at the time of death. More often, pictures were taken by medical personnel for their future teaching material, or for unit case logs. Of the 379 that reported detainees being photographed, 42% (159) reported that these included faces. Of these 159, 32% (51) explained this was only in the case of facial injuries or other medical findings involving the face. Of the 159, 7% (11) explained this was only with permission by the detainee to include the face, and 3% (4) explained this was for the post-mortem or investigation documentation described above.

b. Many of the individuals who reported that pictures were not taken of detainees explained that this was specified (i.e., not allowed) in either a unit policy or an AR.

c. A few individuals reported personal concern that the use of photography in their unit made them uncomfortable, even when it was done as part of medical documentation or future personal teaching material. One individual reported that when she made these concerns known to other members of her unit, she was socially isolated from her co-workers (Interview # 543).

d. While AR 190-8, paragraph 1-*5d*, strictly prohibits photographing EPWs, RPs and CIs "for other than internal internment facility administration or intelligence/ counterintelligence purposes," the 2004 edition of the Emergency War Surgery text (Chapter 34) advocates units having a digital or other high quality camera for use in medical documentation of EPW injuries. This text also advocates the inclusion of faces in these pictures for accurate, efficient, and complete documentation of patient injuries and surgical interventions. In addition, AR 40-66 (which is not specific to detainees), paragraph 3-1*b*, allows photographs to be "mounted on authorized forms and filed in medical and dental records." Paragraph 2-8*b*(8)*(b)* further requires that consent must be obtained to release photographs "of a person or of any exterior portion of his or her body" for the purpose of research.

18-16. Recommendations

a. DA guidance (DoD level is preferable) should:

(1) Authorize photographing detainee patients for the exclusive purpose of including these photos in medical records, and not require informed consent for photographs used in this manner (consistent with AR 40-66).

(2) Mandate that photographs of detainees taken by medical personnel for other reasons, including future personal education material, research, or unit logs, must first have informed consent from the detainee.

b. Guidance for the above should be included in AR 190-8, which is currently under revision.

Section VI
The Use of Behavioral Science Consultation Teams (BSCT) in the Interrogation Process

18-17. General Findings

a. BSCT personnel are not serving in a health care provider role.

b. There is no indication that BSCT personnel participated in abusive interrogation practices.

c. BSCT personnel presently do not have access to detainee medical records.

d. The BSCTs provide forensic psychological expertise to ensure the interrogation process is conducted in a safe, legal and ethical manner.

18-18. Findings - Operation Enduring Freedom

There was no use of BSCTs in Afghanistan; however, the Team was informed that a BSCT was in route to support interrogation activities.

18-19. Findings - Guantanamo Bay Detention Facility

a. The Team interviewed seven AC psychiatrists, psychologists, and a behavioral science technician providing direct support to the Joint Interrogation Group (JIG) at GTMO (three presently serving and four served previously at GTMO). They were assigned to CSCs with duty at GTMO.

b. There is no doctrine or policy that defines the role of behavioral science personnel in support of interrogation activities; however, there are SOPs which describe the role and responsibilities of personnel serving in a BSCT role (Cit. 13). The rating chains for these personnel were not in medical channels. BSCT personnel are rated by the JIG Commander and senior rated by the Commanding General or Chief of Staff of the Joint Task Force (JTF) GTMO.

c. Personnel serving in a BSCT role at GTMO provided behavioral science consultation to the JIG and JTF command group. Physicians/psychiatrists and psychologists were initially assigned to this duty in 2002. Since mid year 2003, the positions have been filled by psychologists. The duties of the BSCT include:

(1) Reviewing detainee information.

(2) Providing opinion on character and personality of detainee.

(3) Assessing how dangerous a detainee might be (ref. release and potential future combat role).

(4) Providing opinion on behavioral science aspects of the camp and camp organization and procedures.

(5) Consulting on interrogation plan and approach.

(6) Providing feedback on interrogation technique.

(7) Teaching behavioral science topics to interrogators.

d. The BSCT personnel observed interrogations but were not active participants in the interrogation process.

e. The BSCT personnel were not medically credentialed at GTMO and did not provide any medical services in the medical treatment facility. Several BSCT personnel did have access to the detainee medical records. In June 2004, BSCT were no longer permitted to directly review detainee medical records. The BSCT personnel did not document the medical condition of detainees in the medical record but did keep a restricted database which provided medical information on detainees. BSCT personnel never provided psychological services for detainees but on two occasions consulted with interrogators who were experiencing non-work related stress.

f. Two of the seven personnel interviewed did feel conflicted while serving in the BSCT role. The conflict centered on the lack of SOPs, policy and guidance on how to function in this role. In both instances, the conflict was resolved through refinement of procedures and establishment of SOPs. Every interviewee felt that medical personnel should serve in a BSCT position for interrogation activities, but recommended using psychologists, not physicians/psychiatrists, in this role.

g. In the realm of training, all BSCT personnel were familiar with the Geneva Conventions but only four out of seven felt their training prepared them for addressing the human rights issues of detainees. The psychologists did go through limited training at Fort Bragg Resistance Training Laboratory prior to taking on the BSCT role at GTMO.

h. There was one incidence where a BSCT member was aware of potential abuse as he was present when the Federal Bureau of Investigation (FBI) reported the incident to the JIG Commander. Apparently the abuse involved an interrogator pulling on the thumbs of a detainee. Another BSCT member reported a questionable incident where a female interrogator took off her battle-dress uniform (BDU) jacket, rubbed her breasts against the body of the detainee being interrogated, sat on his lap and whispered in his ear. The interrogation was stopped and the individual was reported for her inappropriate behavior to the chain of command.

18-20. Findings - Operation Iraqi Freedom.

a. The Team interviewed four psychiatrists and psychologists (two presently assigned and two previously assigned) who provided direct support to the Joint Interrogation and Debriefing Center (JIDC) at the Abu Ghraib detention facility. These officers were assigned to this task through various methods. One was assigned to the General Staff of (b)(2)-2; 4 interviewees were listed on paper as part of a CSC with duty at the JIDC. The rating chain and technical reporting chains at this time are through the JIDC commander with senior rating by the Commander of (b)(2)-2

b. There is no overarching DoD or DA policy or doctrine for employment of medical personnel in a BSCT role. The first Abu Ghraib BSCT member, a physician, was assigned in the January 2004 timeframe and only remained onsite for 33 days. The officer developed a proposed job description that he could ethically execute; the duties included providing assessments for the psychological fitness of detainees to be interrogated. In June 04, a psychologist was assigned to the (b)(2)-2 staff. As a BSCT member, he served as a consultant and special staff officer. He did not wear the Medical Service Corps branch insignia but wore the General Staff insignia on his uniform. His BSCT role was to ensure interrogations were safe and ethical. He observed interrogations, consulted with interrogators concerning techniques, suggested wording and questions that the interrogator could use, and reviewed all interrogation plans.

c. The BSCT personnel at Abu Ghraib did not provide medical services to the detainees. They did not have access to the medical records of detainees; however, they did have knowledge of detainee medical conditions. In recent months this has changed – they no longer have knowledge of medical conditions. The medical staff provides information regarding medically-related limitations for a detainee undergoing interrogation; however, the specifics of the medical condition(s) is not revealed.

d. The medical condition of detainees is not documented by BSCT personnel except in extreme examples. One BSCT member completed a psychological referral request for a detainee and, in another instance, informed the medical personnel when a detainee had a Post Traumatic Syndrome Disorder (PTSD) reaction during interrogation and was referred for mental health care. The BSCT personnel did not maintain medical records on detainees.

e. Three of the four personnel serving as a BSCT at Abu Ghraib felt conflicted while working in that position. The conflict was based on three issues: (1) the BSCT personnel did not want detainees to view them as health care providers; (2) the BSCT role is an isolated position, an advocacy duty which can get lonely; and (3) concern about the lack of mental health services for detainees, especially the children (this was in January 2004 and is now rectified). The conflicts were resolved by seeking advice from trusted colleagues with more experience and establishing services to support the mental health needs of the detainees.

f. All of the BSCT members thought that medical personnel should serve in a BSCT role for interrogation activities. One BSCT articulated that he did not think physicians/psychiatrists should serve in this role since no medications are provided and it is not a health care provider position.

g. In the training realm, all BSCT personnel were familiar with the Geneva Conventions and three of the four felt their training prepared them for addressing the human rights issues of detainees.

h. At Abu Ghraib, no BSCT personnel observed possible detainee abuse in the interrogation setting. No cases of potential abuse have surfaced when a BSCT member was involved with interrogation.

18-21. General Discussion

a. In the purest sense, the mission of the BSCT is to provide forensic psychological expertise and consultation in order to assist the command in conducting safe, legal, ethical, and effective interrogation and detainee operations. Several of the psychologists and physicians described the position as a "safety officer" for the interrogation process. While serving in this role the objective is to:

(1) Provide psychological expertise in order to maximize the effectiveness of the legal interrogation process.

(2) Provide psychological expertise to assist the command in ensuring that the interrogation process is conducted in a safe, legal, and ethical manner.

(3) Promote the overall effectiveness of detainee operations.

b. The BSCT provides checks and balances in the interrogation process. Initially, BSCT personnel struggled with their role in this arena; the lack of doctrine and policy contributed to their "discomfort." The initial lack of an information firewall between the BSCT personnel and the medical records of the detainees provided a tenuous situation that was later alleviated by prohibiting BSCT personnel from having access to medical records.

c. Those serving in a BSCT role did not feel the assignment of physicians in this capacity was the best utilization of their skills; they could be used more effectively in the patient care arena. In fact, physicians in this role only confused the situation since BSCT personnel provided no direct medical care or services. Psychologists have served in similar roles in Special Forces units, as well as in civilian forensic settings, and their background and training provides a foundation for duty as a BSCT member.

d. The issue of "dual agency" for medical professionals serving in the BSCT role has been raised. Medical personnel serving in BSCTs understood their role and clearly understood they were not permitted to provide health care services. Recent published

articles suggest that "physicians and other medical professionals breached their professional ethics and the laws of war by participating in abusive interrogation practices." There is no indication that any medical personnel participated in abusive interrogation practices; in fact, there is clear evidence that BSCT personnel took appropriate action and reported any questionable activities when observed.

e. BSCT personnel served as protectors, much like a safety officers to ensure the health and welfare of the detainee under interrogation. In reviewing interrogation plans with the ability to halt interrogations at any time, BSCT personnel provide the oversight and checks and balances in the interrogation process.

18-22. General Recommendations

a. DoD develop well-defined doctrine and policy for the use of BSCT.

b. DA (preferably DoD) policy should permit only BSCT personnel to participate in interrogation planning.

c. Psychiatrists/physicians should not be used in a BSCT role.

d. All psychologists and behavioral health technicians serving in BSCT positions should receive structured training on the roles and responsibilities while functioning in this capacity.

e. MI personnel should clearly understand the defined roles, responsibilities and limitations of behavioral health personnel serving in a BSCT position.

f. All psychologists utilized as BSCT members should be senior, experienced personnel.

Section VII[1]
Medical Personnel Interactions with Interrogators[2]

18-23. General Findings

a. Medical personnel participation in interrogations was exceedingly rare (five instances), occurred only in OIF, and occurred exclusively at units providing level I or II care.

b. Evaluation or treatment of detainee patients was rarely (2.3%) delayed for intelligence gathering purposes.

[1] Note: Question sets were tailored by the Team for particular MOS/job duties. Therefore, all questions were not asked of all interviewees. This accounts for the differing numbers of interviewees responding to particular questions.
[2] This observation does not include information relating to BSCT personnel.

c. Medical personnel were rarely (5%) requested to be present during interrogations.

d. Many interviewees reported that policies addressed the interaction between medical personnel and interrogators. However, dissemination and awareness of these policies was inconsistent.

e. In OEF and OIF, dissemination and awareness of these policies improved for level III care personnel as the theaters matured.

18-24. Discussion - Operation Enduring Freedom

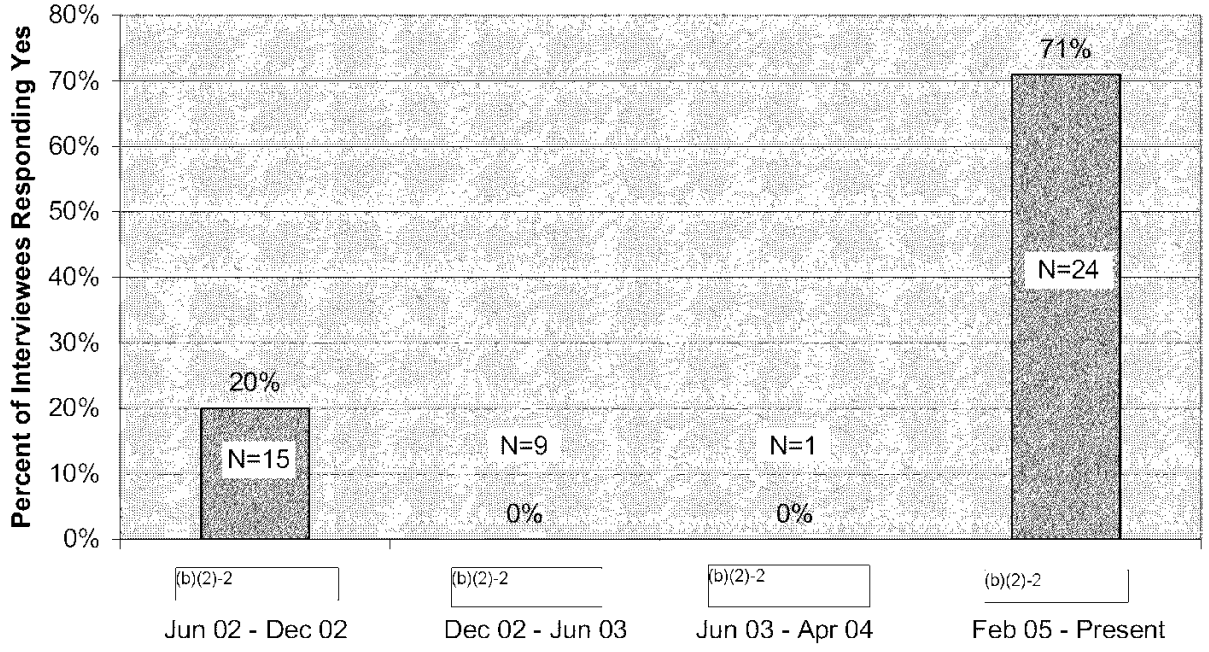
a. *Interrogation Policies*

(1) 92 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility (Questions 62 and 63).

(2) 43 interviewees provided level I and II medical care to detainees. 51% (22 of 43) reported the existence of a written or verbal unit policy.

(3) 49 interviewees provided level III care to detainees. The chart below details the percentage of "Yes" respondents at all level III facilities in the theater. "N" is the total number of respondents per MTF. Approximate MTF dates of service are included.

OEF Level III MTFs: "Was there either: 1) a policy on interrogators, or 2) a policy on conducting interrogations in their medical facility?"



b. *Delay of Initial Medical Exams*

(1) No interviewees were ever asked to delay an initial detainee medical examination until after an interrogation, and none delayed an initial detainee medical examination until after interrogation (Questions 128 and 129).

(2) No interviewees were aware of others being asked to delay an initial detainee medical examination until after an interrogation, and none were aware of others who delayed a initial detainee medical examination until after interrogation (Questions 130 and 131).

c. *Medical Personnel Presence During Interrogations*

(1) The Team interviewed sixty-six (66) individuals and asked:

(a) Had they ever been asked to be present during interrogations? (Question 65);

(b) Had they ever been present during interrogations? (Question 66);

(c) Were they aware of other medical personnel being asked to be present during interrogations? (Question 67); or

(d) Were they aware of other medical personnel being present during interrogations? (Question 68).

(2) 41 interviewees provided level I or II detainee medical care.

(a) 7% (3 of 41) were asked to be present during interrogations;

(b) 17% (7 of 41) were present during an interrogation;

(c) 5% (2 of 41) were aware of others being asked to be present during interrogations, and

(d) 15% (6 of 41) were aware of others being present during an interrogation.

(3) 25 interviewees provided level III care. All answered "no" to all four questions.

d. *Medical Personnel Participation In Interrogations*

(1) 78 interviewees were asked if medical personnel were ever asked to participate in interrogations (Question 57).

(2) All answered "no."

18-25. Discussion - Guantanamo Bay Detention Facility

a. *Interrogation Policies*. 9 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility. Three responded yes, three responded no and three reported being uncertain.

b. *Delay of Initial Medical Exam*

(1) No interviewees were ever asked to delay an initial detainee medical examination until after interrogation, and none delayed an initial detainee medical examination until after interrogation.

(2) No interviewees were aware of others who were ever asked to delay an initial medical examination until after interrogation, and none were aware of others who delayed an initial detainee medical examination until after interrogation.

c. *Medical Personnel Presence During Interrogations*. No interviewees were asked to be present during interrogations, were ever present during interrogations, were aware of others being asked to be present during interrogations, or were aware of others ever being present during interrogations.

d. *Medical Personnel Participation In Interrogations*. No interviewee was ever asked or aware of medical personnel being asked to participate in an interrogation.

18-26. Discussion - Operation Iraqi Freedom

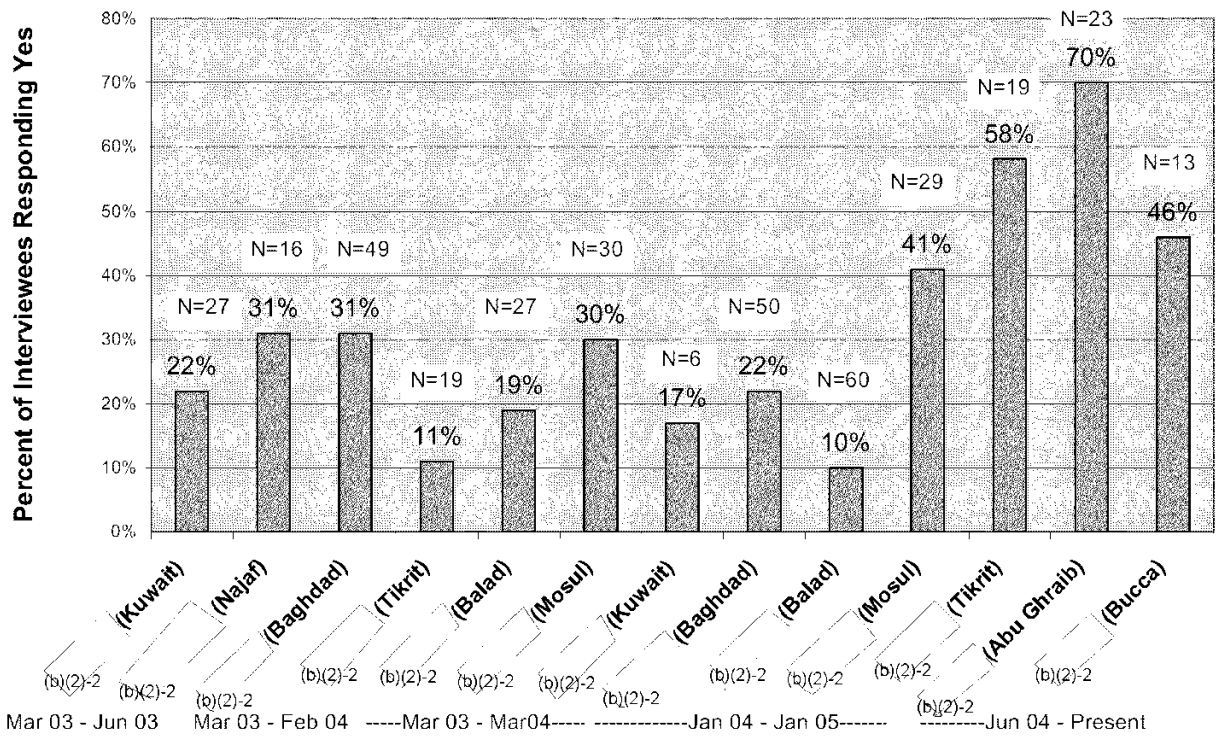
a. *Interrogation Policies*

(1) 883 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility (Questions 62 and 63).

(2) 507 interviewees provided level I and II medical care to detainees. 27% (136 of 507) reported the existence of a written or verbal unit policy.

(3) 376 interviewees provided level III care to detainees. The chart below details the percentage of "Yes" respondents at all level III facilities in the theater. "N" is the total number of respondents per MTF. Approximate MTF dates of service are included. Many MTFs performed split operations and facility locations are annotated in parentheses.

OIF Level III MTFs: "Was there either: 1) a policy on interrogators, or 2) a policy on conducting interrogations in their medical facility?"



b. *Delay of Initial Medical Exams*

(1) 4% (17 of 436) of interviewees had been asked to delay an initial medical examination until after an interrogation.

(a) 1.4% (6 of 436) refused.

(b) 2.5% (11 of 436) delayed initial medical exams.

(2) 3.2% (14 of 435) of interviewees were aware of others being asked to delay an initial medical examination until after interrogation.

(a) 1.4% (6 of 435) refused.

(b) 1.8% (8 of 435) delayed initial medical exams.

c. *Medical Personnel <u>Presence</u> During Interrogations*

(1) The Team interviewed 777 individuals and asked:

(a) Had they ever been asked to be present during interrogations? (Question 65);

(b) Had they ever been present during interrogations? (Question 66);

(c) Were they aware of other medical personnel being asked to be present during interrogations? (Question 67); or

(d) Were they aware of other medical personnel being present during interrogations? (Question 68).

(2) 495 interviewees provided level I or II detainee medical care.

(a) 6% (32 of 495) were asked to be present during interrogations;

(b) 10% (48 of 495) were present during an interrogation;

(c) 8% (39 of 495) were aware of others being asked to be present during interrogations, and

(d) 12% (57 of 495) were aware of others being present during an interrogation.

(3) 282 interviewees provided level III care.

(a) 2% (7 of 282) were asked to be present during interrogations,

(b) 9% (26 of 282) were present during an interrogation,

(c) 6% (17 of 282) were aware of others being asked to be present during interrogations, and

(d) 13% (37 of 282) were aware of others being present during an interrogation.

d. *Medical Personnel Participation In Interrogations*

(1) 793 interviewees were asked if medical personnel were asked to participate in interrogations (Question 57).

(2) 99.4% (788 of 793) answered "no."

(3) 6% (5 of 793) participated in interrogations. Descriptions are below:

(a) Two interviewees fluent in Arabic served as translators for interrogations.

(b) One interviewee fluent in Arabic was asked to gather intelligence for interrogators.[3]

(c) One physician was asked to feign evaluations and treatment on detainees by (i) doing a DNA test from a hair sample, (ii) doing a DNA test from a buccal swab, or (iii) providing cough syrup but informing the detainee it was truth serum. The physician complied with the first two requests, but refused to comply with the third. He thereafter refused any further involvement by himself or any of his medical personnel.

(4) One medic agreed to gather intelligence upon developing a rapport with detainees.

18-27. General Recommendations

a. DA guidance (DoD level is preferable) should:

(1) Prohibit all medical personnel from participating in interrogations.[4] This includes medical personnel with specialized language skills serving as translators.

(2) Empower medical personnel to halt interrogations when any examination or treatment is required.

b. All military personnel should be trained on the above recommendations.

c. Scenario training is highly recommended.

d. Follow-on competency evaluations should be incorporated into all training guidance and plans.

Section VIII
Stress on Medical Personnel Providing Detainee Medical Care

18-28. Findings

a. 5% (41 of 803) of the interviewees (past) volunteered to discuss their personal experiences in providing care to patients in theater. No question asked medical personnel to volunteer their experiences and to describe the emotional impact of their

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[3] The medic (interview #979) felt this role was inappropriate as he was unable to provide detainee medical care while serving as a translator.

[4] For purposes of this recommendation the term "participating in interrogations" refers to the active participation by medical personnel during an interrogation. For example, asking questions would be active participation. Medical personnel who assist in developing the plan of interrogation are not deemed to be "participating in an interrogation." Likewise, actual presence in the interrogation room may not constitute "participating in an interrogation." For example, personal observation by medical personnel to ensure the health and welfare of the detainee is not deemed to be "participation in the interrogation."

experiences. If the question had been asked, the actual numbers of responses might be higher.

b. 3.7% (30 of 803) of the interviewees reported that training should be required to prepare medical personnel for the ethical challenges and stressors associated with the theater environment, trauma care, detainee care, and the challenges of providing care with limited resources.

18-29. Discussion

a. 5% (41 of 803) of the interviewees (past) described their own personal experiences in providing care to patients in theater. No question asked medical personnel to volunteer their experiences and to describe the emotional impact of their experiences. If the question had been asked, the actual numbers of responses might be higher. Responses fell into the following categories:

(1) Ethical dilemma of providing care to insurgents that killed or injured U.S. Soldiers.

(2) Providing care to U.S. Soldiers and Iraqis with limited medical resources.

(3) Quantity and severity of the injuries.

(4) Stress of a warfare environment.

b. "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care?" was asked. The majority of past interviewees answered the question (Q6-803 respondents and Q8-800 respondents). Thirty interviewees reported that training should be required to prepare medical personnel for the ethical challenges and stress associated with the theater environment, trauma care, detainee care and the challenges of providing care with limited resources.

c. Some medical personnel reported that our interviews re-surfaced memories of their experiences. Several Soldiers identified the interview as the first opportunity to share personal experiences.

d. Some medical personnel did previously discuss their deployment experiences because they had provided care to detainees. They felt that providing detainee care devalued their deployment experience. A hospital executive officer emphasized "the enormous difficulty of being on a ward 24/7 with 20 detainees that just came off the battlefield from trying to kill American soldiers. There is no training scenario in the Army that prepares you for that" (Interview #234). The commander of a hospital described the extremely difficult work environment of the nursing staff providing detainee care. He then commented that he was very proud of their commitment to provide quality care. Several nurses assigned to a CSH talked about detainees hissing, spitting, defecating

and urinating on the floors of the ward, despite the interpreters informing detainee patients this was unacceptable. Another interviewee commented that she was a mid-deployment replacement and that she received no pre-deployment training. She adds that medical personnel must be prepared for the psychological aspects of providing detainee care.

e. Sixteen interviewees described the emotional aspects of caring for detainees. More specifically, five related their personal challenges in providing care to insurgents that killed or injured U.S. Soldiers. One nurse commented that "the detainee health care mission was very difficult and that there was much stress involved when dealing with detainees day-to-day and that sometimes personal attitudes changed, particularly if the detainees tell you that once they are released they will come back and kill you" (Interview #781). A physician characterized the "stress as unique in dealing with detainees; for example, the emotional aspect of dealing with those who were killing U.S. Soldiers and the responsibility in caring for them. Very difficult for the young medics to work through the ethics conflict" (Interview #400). A nurse simply conveys "preparing for the psychological effect of taking care of one who has tried to harm your fellow Soldier" (Interview #316).

f. Although many interviewees commented on trauma training, only a few statements captured personal experiences relating to trauma care. For example, a nurse anesthetist describes "spending resources on Iraqis no differently than American soldiers. One thing that sticks in my mind is that we expended hardware, blood, medications, supplies on an insurgent who shot an American Soldier and then had to call for blood drives at night for the next Soldier because we had expended resources on Iraqis" (Interview #159). Another nurse anesthetist assigned to another CSH commented that training should be focused on the ethical dilemmas of caring for detainees since it was a struggle; for example, "a detainee was severely wounded and we gave him the required blood, knowing that we might not have the blood for our injured soldiers. This is something that we dealt with everyday" (Interview #685). A company commander commented: "It was very challenging to deal with massive trauma. There is no place to get away from it. The reality of war is tough" (Interview #212). Finally, a CSH Chief Nurse stated: "there's never a break, trauma everyday 24/7" (Interview #680).

g. When asked "How comfortable did you feel discussing ethical issues related to detainee care with your immediate supervisor?" 934 of 993 (94%) (past, present and future) interviewees responded with "very comfortable" and "comfortable." Some commented that it was discussed regularly and others commented that it was not an issue; therefore, it was not discussed. Two medical treatment facilities reported convening an ethics meeting regularly (interviews #274 and #612). A few interviewees raised concerns and addressed them through the chain of command.

h. 28% (43 of 152) past/present respondents at level I in OIF graded availability of medications as either poor, fair or neutral and 26% (39 of 152) graded medical supplies as poor, fair or neutral. Interviewees commented that medical materiel sets and the

initial medical supply system did not provide for chronic illnesses, definitive and rehabilitative care necessary for detainee care; for example, a physician and two 91Ws, all from different units, commented that, initially, they were not resourced to treat medical conditions such as diabetes and hypertension (Interview #s 693, 132, and 512). Many interviewees commented that the availability and use of supplies was the same for both U.S. Soldiers and Iraqis and there was no difference in who received the resources. A 91W assigned to a MP unit commented "I used all of the resources I had for our Soldiers on the detainees and sometimes we didn't have enough" (Interview #95).

18-30. Recommendations

a. MEDCOM should establish an experienced SME Team comprised of a psychiatrist, a psychologist, clinical representation from all levels of care, and include representation from a Chaplain. The team should:

(1) Comprehensively define the training requirements for medical personnel for inclusion into their pre-deployment preparation.

(2) Consider revising CSC doctrine to effectively deliver support to medical personnel in theater.

(3) Develop an effective system to regularly monitor post deployment stress.

(4) Refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

b. AMEDDC&S should develop the training content defined by the above team. The above team should approve the content. The training (not all inclusive) should include ethical dilemmas medical personnel face and the emotional aspects in providing care to insurgents and detainees.

c. MEDCOM should assure post deployment mental health assessment of medical personnel and provide follow-up care.

Section IX
Interviewee Training Requests

18-31. Training Questions

a. The Team asked the following of interviewees: "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? Format? How often? When?"

b. The following provides responses from past/present OIF/GTMO/OIF interviewees.

18-32. Operation Enduring Freedom

a. Exceedingly few interviewees felt that current training was sufficient, and nearly all felt strongly that training in general needed significant upgrading. The most commonly recommended topics were: pre-deployment: cultural awareness training (including religious differences, local customs, accepted societal behaviors, diet, etc.), basic medical and conversational language training for the respective area of operation, emphasis on triaging and treating detainee patients and U.S./Coalition patients in the same manner, and Medical Rules of Care (ROC).

b. Responses concerning the desired frequency of training were quite varied, including: annually, semi-annually, quarterly, and monthly for deploying units; during annual training (AT); and at all training locations with follow-up given at regular intervals. Responses were also varied concerning when the training should occur, to include: unit training at home station upon receipt of warning orders (varying from 30-365 days in advance of deployment) with increased training as mobilization approaches; just before mobilization with refresher in theater; and only in theater.

c. For comparison purposes in some training areas, responses were grouped by officer and enlisted personnel. Officers (physicians, nurses, and PAs) generally stated a learning preference towards a PowerPoint lecture format (with topics including local endemic diseases), while enlisted personnel generally favored scenario-based and hands-on training (with topics including staff safety and the securing of detainees).

18-33. Guantanamo Bay Detention Facility

a. Responses were centered specifically on the provision of medical care while deployed to GTMO, including the security of detainees and universal precautions.

b. Responses concerning the desired frequency of training were as similarly varied as the OEF responses. Nearly all stated that while training should occur before deployment, some form of refresher training should occur after arrival in theater.

18-34. Operation Iraqi Freedom

a. Training content suggestions were similar to those voiced in OEF, but also included: stress management for medical personnel; retraining for subspecialists utilized in other roles (e.g., primary care, ER, or general surgery); interactions with OGAs, MI personnel, and interpreters; field sanitation issues; preparation for long-term care of detainees; treatment of blast and gunshot injuries; and interest in having more MASCAL exercises. Of note, when Geneva Convention training was mentioned, only one interviewee recommended AR 190-8 training, reflecting a widespread lack of familiarity with this AR. Additionally, the number of responses that included desired training related to security of detainees was strikingly higher than those received in the other two theaters.

b. Responses concerning both the desired frequency and the timeframe of training were also similar to those voiced in OEF, although some interviewees also wanted detainee training added to annual common task training (CTT) requirements. It was repeatedly recommended that refresher training in theater was universally desired regardless of when or where original training took place. It was also suggested that JRTC and NTC be made prime training locations for detainee operations.

c. Desired training methods (lectures vs. scenarios) were also similar to those voiced in OEF.

Chapter 19
Non-AMEDD Training Sites

Section I
Overview of Non-AMEDD Training Sites

The Team visited numerous non-AMEDD training sites to glean a perspective on training initiatives relative to the detainee health care mission. The visits provided critical insights into the types of training, and the time allocated for tasks pertinent to detainee medical operations. The Team interviewed personnel at JRTC, NTC, the PPPs and CRCs, and the MI school.

Section II
Joint Readiness Training Center (JRTC)

19-1. Findings

a. The Iraq theater is replicated at the JRTC platform. Two hundred to four hundred Iraqis are hired to play various roles to include the four to five terrorist groups. The majority of scenario play is trauma. The detainee center is located next to the hospital.

b. The medical scenarios address detainee care from the point of injury to level III. When asked if simulated care was documented, the response was that it was very difficult to do the documentation in the limited amount of time provided to complete the task.

c. It was reiterated that the observer controllers (OC) do not evaluate training, but observe the training. Therefore, OCs observe but do not evaluate medical ethics training, Law of War training and Geneva Conventions training.

d. Medical ethics training as it relates to medical care is not annotated in the written AAR.

19-2. Discussion

a. OCs request tactical unit SOPs for review prior to start of exercise (STARTEX). If SOPs are missing, then the OC will coach them through to completion prior to STARTEX.

b. There were no formal checklists, rather the OCs draw from their personal experiences.

c. Scenarios are tailored to the needs of the unit's mission in theater and dynamic to reflect the changing picture in theater.

d. OCs expressed concerns that there were no selection criteria to serve as an OC and it impacts on the quality of the training. It was mentioned that AC and USAR personnel often arrive with no deployment experience to serve as an OC.

e. OCs stated their future plans are to develop scenarios to improve the quality of training. In order to improve the quality of training, they seek input from units in theater or from units that have recently returned.

19-3. Recommendations

a. Establish a SME team comprised of expertise from clinicians to develop the tasks and framework to formalize the training program. The framework should encompass all levels of care, from point of capture to care in the detention facility.

b. The above team should assess the current training, specifically the scenarios to determine training deficiencies and determine the best practices in improving the quality of training as it relates to detainee medical care.

c. Since AMEDD personnel must be prepared to provide care across the entire healthcare spectrum in theater, from the point of capture and collection point to the prison facilities, the training content should be developed by medical personnel with exceptional knowledge of detainee care. Additionally, the team should be comprised of representation from JAG, a medical ethicist, and subject matter experts serving in the prison health care system. The team members should develop the content and the JRTC medical OCs should facilitate.

d. Team membership should include representation from the NG and USAR personnel that served in these facilities as well as the active component.

e. The training should include a crosswalk of DoD and DA regulations and policies pertaining to detainee medical care. Training content should be revised regularly to reflect changes in the policies.

f. Define competencies for observer controllers. Ensure OCs are from every component.

Section III
National Training Center (NTC)

19-4. Findings

a. The NTC scenario has evolved to mirror the Iraqi theater.

b. The NTC Rules of Engagement (ROE) have evolved to include detainee operations including medical care.

19-5. Discussion

a. In 1999, the NTC scenarios first incorporated Civilians on the Battlefield (COB) training. This was not medical training per se and there was no casualty play or casualty evacuation of COBs at that time. Since the start of OIF, the scenario for NTC changed significantly and on a large scale. No longer was the linear battlefield and high intensity conflict the focus of the training scenarios. Specifically, the scenario changed so that the cantonment area simulates the experience of Kuwait in the deployment process. In the box, the scenarios are focused on Iraq with a large amount of realism. There are now Forward Operating Bases (FOBs) established at the battalion level for the scenario training. Also there are Iraqi cities in the box with Iraqi nationals hired as contractors from the Titan Corporation. They speak Arabic and interact with the training soldiers in as realistic manner as possible.

b. In 2002 to 2003 the NTC ROE changed. Prior to this, Opposing Forces (ORFOR) automatically became killed in action (KIA) if captured and there was no scenario play for detainment operations or detainee care and support (including medical). Detainee Operations are now part of the standard scenario training and the medical ROE is a big part of the planning including treatment, evacuation, and care. In the Leader Training Plan (LTP) "pre-course," the medical ROE is briefed to include information on entitlement and treatment. Medical leaders are provided with references in the form of the 8 and 4 series FMs as well as access to the Tarantula AKO shared site which has the actual medical ROE for OIF, FMs, and example tactical SOPs (TACSOP). Access to this AKO shared sight is for all who request subscription on the AKO site at: AKO → Files → US Army Organizations → FORSCOM → Irwin → NTC Operations Group → Tarantula Team → Tarantula 2/4 → Rotational folders.

c. Resources available to deploying units include the JTF-7 Smart Card with non-medically related translation phrases. Units are informed of this resource and of the Palm Phrasalator software that is used by some in the field to do translations for medical and non-medical purposes.

19-6. Recommendations. The Team endorses the following specific recommendations from the NTC trainers:

a. Add a detainee medical operations specific task to the Expert Field Medical Badge (EFMB) task list.

b. Add detainee medical operations into combat lifesaver (CLS) training – the true first interface between the fighting force medical provider and the detainee.

c. Commanders need to incorporate detainee medical operations into the METL.

Section IV
Power Projection Platforms (PPPs)

19-7. Findings

a. PPPs do not offer classes on the generation, collection and storage of detainee medical records or on specifically reporting detainee abuse.

b. Training at the PPP is directed from 1st Army or 5th Army. It is undetermined if enough time could be allocated at these facilities to conduct training specifically geared to prepare medical units for a detainee care mission in theater.

c. PPPs offer generic Law of War and Geneva Convention classes to soldiers deploying to OEF, GTMO, OIF. The training is not unit or theater-specific.

19-8. Discussion

a. PPPs provide training for deploying soldiers, including a Geneva Convention/Law of War class, often provided by the local legal office. This training is not sufficient to educate medical personnel deploying to a detainee healthcare mission in theater.

b. No training is provided on the generation, storage and collection of detainee medical records or for recognizing and reporting detainee abuse. Medics are often employed at the PPPs to cover ranges or to teach CLS courses.

c. Few PPPs offer theater-specific training.

d. Guidance for mandatory training leaves little time to incorporate additional, necessary, training into the schedule.

e. Training, while meeting the guidelines from higher headquarters (HQ), is widely varied across the PPPs. Detainee Operations training is very detailed for deploying MP units, but not medical units.

f. FTX training at the PPP does allow for unit-specific METL training.

19-9. Recommendations

a. PPPs need to ensure medical personnel deploying are able to use their time at the training site to prepare for their upcoming mission. They should not be tasked with non-training missions (such as providing routine medical care) unless a quantifiable training effect can be assessed from such medical care.

b. PPPs need to make their training "theater-specific" to ensure Soldiers processing through are adequately informed of any unique theater challenges or dangers.

c. Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers. Emphasis needs to be placed on reporting suspected or actual abuse.

d. Units should still bear the responsibility of training soldiers on detainee medical records.

Section V
CONUS Replacement Centers (CRC)

19-10. Findings

a. CRCs do not provide classes on the generation, collection and storage of detainee medical records or on reporting detainee abuse.

b. It is undetermined if time can be allocated at these facilities specifically to prepare medical personnel who are deploying to a detainee care mission.

c. CRCs offer Law of War and Geneva Convention classes to deploying individuals. Ft Bliss' CRC does make these classes theater-specific.

d. Ft Bliss' CRC provides a detailed detainee operations class, "Process Enemy Prisoners of War/Civilian Internees (EPWs/Cis) at a Collection Point or Holding Area" (Cit. 48), geared more toward MP and combat arms Soldiers.

19-11. Discussion

a. The training provided on Geneva Convention/Law of War is lecture only and provides no scenario based exercises.

b. The time constraints on personnel processing through CRCs significantly limits increased training opportunities.

c. Personnel qualified to instruct detainee medical care classes are currently not available.

19-12. Recommendations

a. CRCs need to look at opportunities to expand current detainee operations training to include more comprehensive teachings on reporting suspected or actual detainee abuse.

b. Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers and use a scenario based component to enhance learning modalities. It needs to emphasize reporting suspected or actual abuse

c. Units should still bear the responsibility of training soldiers on detainee medical records.

Section VI
Military Intelligence Training

19-13. Findings

The Enhanced Analysis and Interrogation Training (EAIT) advanced individual training (AIT) course includes specific training on interacting with BSCT members.

a. 97E AIT includes instruction that interrogations should be postponed or interrupted if a detainee requires any medical evaluation or treatment.

b. The EAIT course includes specific training on interacting with BSCT members.

19-14. Discussion

a. Personnel with the 97E MOS receive a Law of War briefing from the MI JAG office. The only training in the 97E AIT which focuses on interacting with medical personnel emphasizes that any ill or injured detainee is to have an interrogation delayed or interrupted so that medical care can be administered promptly. In the FTX portion of 97E AIT none of the scenarios include moulaged or injured detainees; however, current scenarios do cover the need to report all suspected abuses inflicted by any other interrogators.

b. New interrogation training doctrine is being developed at the current time. There was a plan to include the interfacing of students with medical personnel, with the goal of increasing sources of general intelligence about detainees. This training is not specifically included in the 97E AIT, since this not described within current training doctrine. However, when current students ask trainers about using medical personnel as sources of general intelligence, this is not discouraged.

d. The EAIT was established as an advanced course for Human Intelligence Collectors and Intelligence Analysts who would be working at the GTMO detention facility. The curriculum for the EAIT course is very dynamic, and rather than being driven by doctrine, as is the 97E training, it appears to be driven by

the leadership needs at GTMO for their ever-changing personnel staffing needs/desires. However, even though this course was in fact originally established with a focus on GTMO, many current and future students will be assigned to other theaters of operation.

e. The EAIT course emphasizes the need for students to interact with medical personnel, in particular the BSCT staff; in theaters of operation this interaction is intended to occur 2-3 times per week at a minimum. Students are trained about the roles of the BSCT staff, which include: checking the medical history of detainees with a focus on depression, delusional behaviors, manifestations of stress, and "what are their buttons." Students are also trained that BSCT staff will greatly assist them with: obtaining more accurate intelligence information, knowing how to gain better rapport with detainees, and also knowing when to push or not push harder in the pursuit of intelligence information.

f. During the EAIT course, trainee competency is evaluated during their planning phase for interrogation and analysis, and failure to interact with the BSCT staff is a "NO-GO" in this process.

19-15. Recommendation

DA, or preferably DoD, should exercise oversight in the revision of current interrogation training doctrine to ensure compatibility with the Geneva Conventions, the Law of War, and all policies that apply to medical personnel.

Chapter 20
Incidents and Allegations

20-1. This Incidents and Allegations Table (IAT) groups events by theater. Based on the number of OIF entries that theater is further subdivided into the following categories:

a. Medical records

b. Medical practice/behavior

c. Interrogations

d. Staffing shortages

e. Reuse of supplies

f. Supply shortages

g. Detainee environment

h. Potential abuses by US/Coalition Forces

i. Potential abuses by Iraqis

20-2. The Team identified numerous examples of medical personnel reporting suspected abuse (to medical supervisors, the chain of command or CID). Medical personnel also made on-the-spot corrections and added or changed policies and procedures to prevent reoccurrences.

20-3. The Team referred 3 cases for further investigation (two to CID and one to the chain of command).

a. Procedure performed on a dead Iraqi. This had been investigated in theater and the Soldier received a letter of reprimand. Referred to CID (IAT #72).

b. Medical personnel providing sedatives to a detainee potentially for interrogation purposes; observed by 1 interviewee, but not confirmed by additional interviews. Referred to chain of command (IAT #41).

c. Medical personnel failed to report detainees restrained in excessive heat without adequate water. Referred to CID (IAT #93).

20-4. Many of the listed allegations are either unsubstantiated or disputed by other interviewees.

20-5. The Team found conflicting interview results concerning the possible reuse of certain medical supplies.

20-6. The initial level of staffing and resourcing of supplies, combined with excessive lengths of stay for detainee patients at some level III facilities, at times limited the ability of these facilities to readily accept transfer detainee patients.

20-7. Allegations discussed by media reports and published articles often involved inaccurate facts. Several medical personnel who were interviewed for media stories or other publications state they were misquoted.

a. Close in time suspicious detainee deaths. Both deaths were ultimately determined to be homicides. The first death was not originally classified as a homicide. The changing of the death certificates are unfairly mischaracterized as an attempted cover-up (IAT #2).

b. Intravenous Infusion (IV) placed into a deceased Iraqi. CID had been notified (Investigation later concluded that detainee death was abuse-related). An IV was placed in the body prior to transport to make detainee appear to be alive. The purpose of the unneeded IV was to reduce the risk of a riot by detainees. Mischaracterized as an attempt to cover-up cause of death (IAT #9).

c. Internists and other nonphysicians carrying out amputations and other procedures performed by surgeons. Provider treated a detainee with a nearly severed limb. Interviewee claims he was misquoted (IAT #14).

d. Dentist performing open heart surgery. No evidence found to support this allegation (IAT #15).

e. MP suturing a detainee. Incident was investigated fully by CID. Confirmed (IAT #16).

f. Inadequate mental health assets for detainee care. Individual claims he was misquoted. He did not perform the duties of a psychologist in theater but as a medical platoon leader (IAT #17).

g. Physicians designed interrogation techniques. This statement is misleading. Medical BSCT members did monitor interrogation techniques to ensure the welfare and safety of detainee interviewees. Medical personnel were empowered to immediately stop any interrogation being conducted within Abu Ghraib based on health or safety concerns (IAT #37).

h. Reviving a detainee for continued interrogation. No evidence found to verify or disprove the allegation. Undetermined (IAT #38).

i. Reuse of medical supplies. Conflicting statements by various interviewees. Undetermined (IAT #48).

j. Medical supply shortages. Confirmed (IAT #57).

k. Use of a leash for a detainee. Interview statements provide explanation for limited use as a restraint tool on a single mentally unstable detainee. Explanation is not fully stated in article (IAT #73).

20-8. The Incidents and Allegations Table summarizes in one location the events deemed by the Team to be significant. The Team made a good faith effort to interview all known medical personnel involved in the listed incidents and allegations.

INCIDENTS AND ALLEGATIONS TABLE

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
OEF				
1. Suspicious detainee death	Interview #314	Dec-02	Bagram	Did not observe abuse but was aware of two detainees brought in for post mortem examination who died under suspicious circumstances. The deaths were investigated by CID.
2. Suspicious detainee deaths	Interview #899, NEJM 29 July 04 (Lifton) (Cit. 35)	Dec-02	Bagram	A detainee death was initially thought to be secondary to a pulmonary embolus, and not related to any abuse. The interviewed TF Commander requested an Armed Forces Institute of Pathology (AFIP) autopsy thru CENTCOM and arranged for international physicians (German and Jordanian) to attend. After a second detainee died shortly thereafter, the AFIP forensic pathologist returned with a Jordanian and Korean physician in attendance for that next autopsy, and the first death was evaluated again. This time the cause of death was determined to be homicide. A 15-6 was directed by CJTF-180 commander. CID did a complete investigation. The Team reviewed the final autopsy reports and confirmed that both deaths were concluded to be homicides.
3. Allegation of photos documenting multiple Afghan detainee physical abuses	E-mail from PROFIS Surgeon	Unknown	Kandahar	The surgeon reporting this incident stated it was unclear if the photos were real or fake. Allegation referred to CID by Ft Benning MTF Commander for investigation.
4. Uzbek detainee in Afghanistan captured and at next level reported prior physical abuse	Interview #378	B/T Jul 03-Apr 04	Shkin	Sent to CID for investigation; no fault found.
GTMO				
5. Inappropriate interrogator techniques	BSCT #6	B/T Jun 02 – Dec 02	GTMO	There was one incident where a BSCT member was aware of potential abuse as he was present when the FBI discussed the incident with the JIG Commander. Apparently the abuse involved an interrogator pulling on the thumbs of a detainee.
6. Inappropriate interrogator techniques	BSCT #5	B/T Dec 02-May 03	GTMO	BSCT member reported a questionable incident where a female interrogator took off her BDU jacket, rubbed her breasts against the body of the detainee being interrogated, sat on his lap, and whispered in his ear. The interrogation was stopped and the individual was reported for her inappropriate behavior.
OIF				
OIF - MEDICAL RECORDS ISSUES				
7. Burning of medical records	Interview #431/#271	B/T Jan-Mar 04	Balad	Interviewee #431 stated: (b)(2)-2 mentioned that the records were burned after discharge." Interview #271, assigned to (b)(2)-2 claims records were maintained by the CSH. Unconfirmed on both accounts.
8. Burning of medical records	Interview #435/#681	B/T Jan-Nov 04	Mosul/ Balad	Admitted that as S-3/S-2 he would burn records of those detainees not transferred. Interviewee #681 claims records were maintained by the (b)(2)-2 and copies were given to MPs going to "Area 51" with a detainee, then contradicts by saying they have no idea what happened to the original records after going to "Area 51".

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
9. Death of a detainee/place-ment of IV and packed in ice	NEJM 29 July 04 (Cit. 35) Time Mag 07 Feb 05 (Cit. 47). Interview #970/#917/ #698	B/T Jul 03-Mar 04	Abu Ghraib	The medics and #917 were contacted to evaluate a detainee who was found to be dead upon their arrival. He had a sandbag by his head, a cut over his eye, chest contusions, his knees were "scuffed up," and he exhibited raccoon eyes. #970 documented his findings (physical), but he did not sign a death certificate. #970 was called to pronounce the detainee dead (he has a report in his possession because he did not know how to file this report on an unidentified person). He stated that the detainee had already been pronounced dead by the Iraqi physician on call. This detainee had no prison number, had apparently just been captured, and was not a prisoner of the U.S. military, but of an OGA. Autopsy was recommended. #698 stated that he was called down with #917 and another medic. The medic was instructed to place the IV by the JIDC Director (with OGA personnel present). The IV was placed to prevent the other detainees from rioting (confirmed when investigated by CID). The body was packed in ice and transported to an unknown destination. According to #705, the JDIC Director ordered them not to discuss the incident to anyone, including the B Co Commander,(b)(2)-2 #705 was unaware of incident until interviewed by CID. Also investigated by CIA.
10. Possibility of falsifying detainee death certificate	Interview #415	B/T Jul 03-Mar 04	Undeter-mined	Stated that while working with (b)(2)-2 on two separate occasions, he was pressured by OGA personnel into filling out death certificates on Iraqi Detainees. Stated he was not given the opportunity to examine the dead. Causes of death were later found to be inaccurate. CID investigated.
11. Misrepresenta-tion in med records	Interview #595	B/T May-Jul 04	Baghdad	Interviewee stated: "Changed the spelling of my last name on detainee records; I was told the paperwork would be given to detainees upon release." Was attached to the(b)(2)-2 at the time.
OIF - MEDICAL PRACTICE/BEHAVIOR ISSUES				
12. Physician refusing to treat a detainee.	Fay/Jones report/ Interview #897/#904/ E-mail correspon-dence to Team (Cit. 24)	Dec-03	Abu Ghraib	An MI soldier, in her testimony for the Fay /Jones report, stated that she found a detainee in his cell with a Foley catheter in place but without a collection bag attached. She states that she contacted the physician on duty that night and he refused to see the patient or attend to her concerns. The Team contacted the MI Soldier to get more information about who this physician was. She did not remember his name, nor remember if he was an LTC or a COL, but stated that she could identify him in a picture if given one. The Team spoke to many medics and the few physicians that were working in Abu Ghraib around the time of this incident. The Team was not able to identify this physician. #970 does not meet the description and #706 re-deployed November 03 per email msg dated 25 Mar 05 to Team member.
13. Failure to provide detainee care	Public admission/ Interview by Team member	May-04	Kufa	Started an interview on this medic who informed the Team member he had been interviewed about six times by CID concerning an incident where a Company Commander had shot a wounded Iraqi. He said the subject had "half his head blown off" and it was the worst head wound he had ever seen. He told me that he did not treat the patient because he was "expectant." He did not report the incident because an unmanned drone caught it on film. The case was brought to light by the media during the Company Commander's court-martial.
14. "Internists and other nonphysicians carrying out amputations and other procedures performed by surgeons".	Time Mag 07 Feb 05 (Cit. 47) / NY Times 04 Feb 05 (Cit. 36). Interview #916/e-mail correspond ence to Team from #818	B/T Jul 03-Mar 04	Abu Ghraib	There were approximately 130 casualties, including some with open chest wounds and traumatic amputations. #916 stated that he thought the Time Magazine interview was about staffing shortages and a shortage of supplies. During the interview, he mentioned that he cared for amputees. Several of the casualties sustained traumatic limb amputations in which the limb was not salvageable, but had skin attaching it to the body. #915 did not perform any amputations. In cases where the limb was salvageable, the extremity was wrapped and the patient was evacuated. Interviewee stated he felt misrepresented by the article. A patient was admitted to the hospital with Diabetic Foot Ulcer. The patient did not respond to the antibiotic therapy. The orthopedic surgeon performed the toe amputation in the OR.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
15. Dentist allegedly doing heart surgery	NY Times 04 Feb 05 (Cit. 36)/ Interview # 904/#705	B/T Mar 03-Apr 04	Abu Ghraib	#904 stated there was no dentist assigned to Abu Ghraib during Mar 03 to Jan 04. #705 stated that a dentist may have assisted with the insertion of chest tube during a mortar attack, but did not perform open heart surgery. It is unclear when this allegation could have occurred.
16. Two detainees' depositions describe an incident where a medic allowed a medically untrained guard to suture a prisoner's laceration	Incident #21 in Fay-Jones. Lancet (Miles) (Cit 30)/ Interview # 698 (2nd visit to the unit)	Late 2003	Abu Ghraib	#698 (combat medic (b)(2)-2) was asked by MP if he could place a suture. The MP informed #698 that he was a trained Combat Life Saver. #698 monitored the placement of the suture and subsequently monitored the detainee for signs of infection. The wound healed without difficulty. The detainee statement in the Fay/Jones report states that "a doctor" allowed one of the guards to do the suturing. This is not accurate. Interview #705 (physician, (b)(2)-2 was not aware of the incident until CID notified him in Theater. #705 questioned #698 about the incident and verbally counseled him that a PA or physician needs to review and concur with plan of care before suturing in the future. Incident was investigated by CID.
17. Inadequate mental health assets for detainee care	NY Times 14 Feb 05 (Cit. 36)/ Interview #974/#705	B/T Apr 03-Mar 04	Abu Ghraib	#974 (70B, Platoon Leader, (b)(2)-2 was contacted by (b)(6)-2 (bioethicist) for a telephonic interview for the NEJM. It was #974's understanding that (b)(6)-2 sought information to improve care. He asked #974 about mental health issues, knowing that #974 was a professor of psychology and counseling. #974 informed him that about "5% of the detainees suffered from mental illness." #705 is quoted in the article as follows "for long periods, there was no one to treat mental-health problems among inmates, no doctor qualified to prescribe antipsychotic drugs and other drugs that could have calmed mentally ill detainees." #974 stated that (b)(6)-2 inferred that #974 was performing mental health services. #974 stated that he did not perform mental health services and explained that to (b)(6)-2 as well. He said that (b)(6)-2 asked him about BSCTs and he informed him that he had never heard of that term. #974 stated he was misrepresented in the Times article. The NEJM 06 Jan 05 (b)(6)-2 does discuss BSCTs but does not does not mention #974's comment. The Times article does mention #974's comment, but quotes #705.
18. Line medic given the authority to not treat patients	Interview #545	B/T May 03-Jul 04	Baghdad/ Najaf	#545 stated that he was given the authority by the platoon leader to not treat detainees at point of capture who were considered "too far gone." Once told by Platoon Leader of (b)(2)-2 that he had the option of providing medical care to detainees or not. Was also told by a Medical NCO in Sadr City that he, the Medical NCO, did not always treat detainees at point of capture. Said he treated US personnel first and then detainees if there were enough medical supplies. Team could not locate these two individuals.
19. Contract Iraqi physicians secretly taking medications prescribed to detainees to sell on the black market	interview #246	Spring 2003	Baghdad	Reported through chain of command; responsible individuals fired from contract positions.
20. Abuse of a detainee by a nurse	Interview #717	Early 2004	Balad	The nurse interviewed from the ICU reported that he felt that a nurse from the ICW was abusing detainees. He didn't report it, but counseled the nurse himself and obtained a rights warning card from the MPs. He then threatened to bring the nurse up on charges if his treatment of the detainees did not improve. No additional incidents noted.
21. Abuse of detainee by nurse at (b)(2)-2	Interview #430/#431/ #937	B/T Jan 04-Nov 04	Balad	Nurse struck detainee after he grabbed her. COC notified, administrative action taken. Confirmed by interview #166. The 91WM6 was reprimanded in writing for attempting to defend herself when a detainee grabbed her. #937 believes she tried to choke him or push him away. For corrective training, she provided classes on Law of War and the Geneva Conventions with respect to detainee care.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
22. Death of a restrained detainee who fell due to the restraint	Interview #711	2004	Baghdad	The (b)(2)-2 commander interviewed describes an incident where a detainee died from a subdural hematoma. At the time of the fall, the detainee was restrained to his bed by one wrist and one ankle restraint. The commander determined that the fall was caused by the method of restraint (root cause analysis) and the hospital restraint policy was changed.
23. Observed junior Anesthesiologist drop a litter with a detainee patient hard on purpose three times	Interview #12	B/T Mar-Oct 03	Baghdad	Confronted individual, assigned to the (b)(2)-2 on the spot; reported to OR head nurse. No further incidents.
24. Staff nurses appeared to hold pain medications on detainees to absolute time limit of med order	Interview #582	B/T Aug 03-Feb 04	Balad	Reported to Nursing chain of command at the (b)(2)-2 practice stopped.
25. Staff possibly feeding detainees MREs with pork products on purpose	Interview #582	B/T Aug 03-Feb 04	Balad	Reported to Nursing chain of command at the (b)(2)-2 practice stopped.
26. Alleged directive to withhold pain medications from detainees	Interview # 398/#463/# 459	2004	Northwest Iraq	#398 reported that medical personnel were not allowed to give detainees any pain medications, even Tylenol, Motrin, or aspirin, by order of the detention facility commander for (b)(2)-2 The Team determined that he was actually talking about (b)(2)-2 (b)(2)-2 He brought his concerns to the PA and Bn surgeon. Two other medical personnel were interviewed from (b)(2)-2 (b)(2)-2 The BN Surgeon, #459, stated that all detainee medical resources were good, including medication resources, and that all the resources were the same and not separated. Interview #463 was asked specifically if there were directions from his command about limiting resources for detainees and he stated "no."
27. Delay in care of critically injured detainee	Interview #239	Spring 2003	Kuwait	The first time detainee casualties from Iraq landed at the landing zone (LZ) for the (b)(2)-2 in Kuwait, there was an argument among the (b)(2)-2 leadership about providing detainee care in Kuwait. The casualties waited on the LZ without care for two hours. This resulted in significant patient care delay without changing patient outcome. The (b)(2)- later received approval to treat such detainee emergencies in Kuwait.
28. Quality of care for a detainee	Interview #729	Summer 2003	Bucca	#729 describes watching a medic from another unit attempt to put an IV in a detainee multiple times. The medic placing the IV was "not very good at placing IVs, was yelling at the detainee to cooperate with her, and told the interpreter that she wouldn't care for the detainee if he didn't start to cooperate." The interviewee intervened and placed the IV herself and counseled the medic on the spot.
29. Quality of care for detainees	Interview # 444	Late 2003	Abu Ghraib	When influenza vaccines were available, the unit administered them to detainees. #444 and other medics were counseled from the MP higher HQ for administering flu shots to detainees. Regardless, #444 established a protocol to administer flu shots first to detainees with chronic illnesses, and then to the other detainees.
30. Refusing to accept detainee patients	Interview #172	Spring 2003	Baghdad	The interviewed physician from Camp Cropper (BIAP) recounted a significant problem with detainees having advanced stage TB. #172 reports one child hemorrhaging from his cavitary TB and dying. After that happened he developed a four-drug therapy protocol for TB. He reports that one of his detainee patients was desaturating due to his TB and that the (b)(2)-2 refused to accept this patient in transfer even though there were not the appropriate medical resources at BIAP to treat him. He states that ultimately he stopped calling ahead to the (b)(2)-2 to let them know he was transferring detainee patients to ensure that he would not have these patients blocked for transfer. He was concerned that when he called to report on a critically injured patient he was transferring, the first question he was always asked was "is this a US soldier or a detainee?" He was concerned that this conveyed a bias against accepting detainee patients.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
31. Refusing to accept detainee patients	Interview #444/#904	B/T Apr 03-Apr04	Baghdad	This medic at Abu Ghraib reports that the medical evacuation resources for detainees were poor and felt this was due to the (b)(2)-2 (b)(2)-2 refusing to accept patients in transfer. Two patients that were particularly memorable were a patient with a base of the skull fracture and a patient with partial hand amputation. Ultimately, the fracture patient was accepted in transfer to the (b)(2)-2 which then transferred him to the (b)(2)-2 for level III care. (Interview # 444) His NCOIC (also a medic) reports contacting his Bn command who in turn would contact the BDE command who in turn would contact the (b)(2)-2 who would contact the (b)(2)-2 to transfer these patients. Neither of these medics spoke directly to anyone at the (b)(2)-2 They did report that once they found the (b)(2)-2 they stopped trying to send any patients to the (b)(2)-2 and never had a problem having a detainee patient accepted for transfer the (b)(2)-2
32. Appropriate support of level II medical unit by the (b)(2)-2	Interview #172/#695	B/T May-Oct 03	Baghdad	#172 (board certified Family Practice physician) reports that he would send detainees from the BIAP/HVD detention facility to the (b)(2) (b)(2)-2 for subspecialty consultation. They would be seen by a PA or an NP doing acute care and sent back with the consultation completed by that person, instead of the specialist. He felt this was inappropriate. #695 learned that PAs were running the screening clinics and were not prepared to manage complex medical illnesses. #695 met with the (b)(2)-2 DCCS to discuss his concern. No change in this practice occurred; therefore, he stopped sending these patients and treated them himself at the (b)(2)-2 (b)(2)-2 15 bed Aid Station.
33. Appropriate support of level II medical unit by the (b)(2)-2	Interview #172	B/T Mar-May 03	Baghdad	This physician states that early on in the war (Mar 2003 - May 2003), detainees were being sent back to the HVD detention facility with external fixators in place. He felt this was inappropriate because they were sleeping in the dirt and had a very high risk of infection from their environment. He complained about this to (b)(2)-2 command and ultimately, by June 2003, the (b)(2)-2 (b)(2)-2 sent a delegation of command staff to the HVD detention facility to see what the environment was for the detainees. After they saw the conditions, they stopped sending patients back that couldn't safely receive their post-operative care at the detention facility.
34. Appropriate care of detainees by the (b)(2)-2	Interview #172	B/T Mar-Aug 03	Baghdad	#172 recalls a conversation he had with the OMF surgeon from the (b)(2)-2 that concerned him. #172 had sent a patient with an open facial fracture involving the maxillary sinus from the BIAP to the (b)(2)-2 He asked the OMF surgeon how this patient was doing when he next saw the OMF surgeon and #172 reports that the OMF surgeon told him that she didn't remember the patient. #172 reports that the OMF surgeon then asked if the patient was a US soldier or a detainee and when #172 stated this was a detainee, #172 reports that the OMF surgeon stated that she didn't always get called on the detainee patients.
OIF - INTERROGATION ISSUES				
35. Simultaneous treatment and interrogation of a detainee	Interview #398/#68/#452/#453/#454/#456/#460	2004	Mosul	Detainee with a gunshot wound simultaneously interrogated in aid station, according to #398. Others interviewed did not mention this or other similar episodes. Soldiers assigned to (b)(2)-2
36. Simultaneous treatment and interrogation of a detainee	Interview #398/#68/#452/#453/#454/#456/#460	2004	Mosul	Detainee with a gunshot wound simultaneously interrogated in aid station, according to #398. Others interviewed did not mention this or other similar episodes. Soldiers assigned to (b)(2)-2
37. "Army officials stated that a physician and a psychiatrist helped design, approve, and monitor interrogations at Abu Ghraib."	Lancet article (Miles); Interview #734, #BSCT 9	B/T Jan -Feb 04	Abu Ghraib	#734 is the "physician" referred to in this article. #734 reported that he and his EMEDS Commander wrote the CONOPS for the JIDC DHT. As the DHT physician, he helped to monitor interrogation techniques, not monitor interrogations directly. Also, he did not develop interrogation techniques. He did not approve techniques, but rather had the authority to stop any technique used anywhere in Abu-Ghraib on the spot and without approval of the BDE FOB Commander. # 734 felt that the Lancet article misrepresents his actual duties at the JIDC.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
38. "In one example of a compromised medically monitored interrogation, a detainee collapsed and was apparently unconscious after a beating, medical staff revived the detainee and left, and the abuse continued."	Lancet (Miles)		Abu Ghraib	The Team found no evidence to verify or disprove this allegation.
39. Physician was asked to participate in interrogations three times	Interview #848	B/T Sep 03-Aug 04	Baghdad	Three requested episodes:1) to pretend to collect DNA with a hair sample; 2) to pretend to collect DNA sample with buccal swab; 3) to provide cough syrup as a "truth drug". He refused #3, and prohibited medical personnel inclusion in any subsequent interrogations. Practice stopped.
40. Medical personnel involved with interrogations	Interview #398/#979	B/T Sep03-Sep04	Northwest Iraq	#398 reports that he was used as an interpreter for interrogations under the direction of the S-2 because he is fluent in Arabic. #398 never acted as a medic during any interrogations, only acted as an interpreter. #979 (combat medic,(b)(2)-2 who is fluent in Arabic, reports that he served as interpreter for intelligence gathering. #979 asked his supervisor to limit the use of his language skills to care for detainees. Despite repeated requests, #979 was told by his medical OIC that he would continue to assist in intelligence gathering.
41. Medical personnel providing sedatives to a detainee so he would talk more during interrogation	Interview #33/#36/#139/#138/#137/#32/ #136/#63/#62	B/T Mar 03-Mar 04	Kirkuk	#33, an LPN from (b)(2)-2 reported that he saw sedatives (ativan, diazepam, etc.) being used by medical personnel to calm a detainee so that the detainee would talk more. #33 did not think it was appropriate. #33 reports that he was asked to do this, but he did not do it himself. Several others in the unit (#36, 139. 138, 137, 32, 136, 63, and 62) were interviewed and none of them reported similar requests or observations. None of them reported administering any medications to assist in the interrogation process. The Team referred this incident to the chain of command after conferring with the CID Staff Judge Advocate.
42. Interrogation on ICW ward	Interview #164	B/T Mar 03-Feb 04	Balad	Interview #164 stated that "if the detainee or EPW was not picked up or claimed by the unit that brought them to us (could be MP or maneuver unit) at the time of discharge, the S-3 cell under the authorization of the Commander released them. Interrogators came to the ward to ask questions of detainees. I don't know who the interrogators were (MPs, MI, etc.). The detainees were taken to the end of the ICW to be questioned. There was a process in which the interrogator had to go to the S-3 shop first. S-3 escorted the interrogator to the ward. I did receive verbal instructions on the procedure for interrogators entering our facility (my ward)."
OIF - STAFFING SHORTAGES				
43. Interrogators used as interpreters	Interview #866//Visit to DIF	Jan-05	Camp Liberty	Interrogators assigned to(b)(2)-2 were used as interpreters for the medical staff during the initial screening of detainees, giving some interrogators access to all of the detainee's medical information. Discussed on-site by Team.
44. Access to detainee medical information	Interview #644	B/T Mar-Aug 04	Baghdad	The translators with the(b)(2)-2 often worked with the interrogators in addition to serving as translators for medical care. It could create a set of conditions for distrust between providers and detainees.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
45. Inadequate personnel resources -- interpreters	Interview #631/#261/ #36/#726/# 259/#237/# 178	2003-2005	Various Locations	Individual medical personnel from the units listed reported that the supply of interpreters strictly for medical purposes was inadequate. One individual reported that the interpreters used for medical purposes were the same as the ones used for interrogation (#36 - (b)(2)-2 (Kirkuk)). One individual reported that they had to rely on other detainees to be interpreters (#726 - (b)(2)-2 (Bucca)). One individual reported that they had to use the interrogators as interpreters because they were the only ones available to be interpreters (#259 - (b)(2)-2 . One individual reported concerns about the quality of the interpreters with concerns that one interpreter was found to be inappropriately touching patients and was fired and another was found to be sending intelligence to Kuwait for retaliation against the Iraqis (#261 - (b)(2)-2 Baghdad). Another individual felt that having Kuwaiti interpreters was inappropriate as they often talked down to the Iraqi patients and were culturally insensitive (#240 - (b)(2)-2 (Baghdad)). One individual had concerns that the interpreter provided to them was not accurate in what he was conveying (#631 - (b)(2)-2 Kuwait)). Two other individuals noted a general lack of availability of interpreters (#237 - (b)(2)-2 #178 - (b)(2)-2 (Mosul)). Founded.
46. Inadequate personnel resources	Interview #917	B/T Jul 03-Mar 04	Abu Ghraib	(b)(2)-2 : The (b)(2)-2 medical section was tasked to support (b)(2)-2 with an ambulance and medical resupply support. (b)(2)-2 mission was to supplement staffing at Abu Ghraib. #917 reported that initially the (b)(2)-2 (b)(2)-2 senior medic assisted the unit, but within a very short period of time the MP medics were not available to assist with sick call. Physicians rotated every 90 days, making it extremely difficult to provide any continuity in leadership. #917 relates that one rotating MP Bn surgeon spent his entire deployment traveling to accomplish the task of establishing a hospital.
47. Inadequate personnel resources -- medical personnel doing guard duty	Interview #240/#173/ #176/#716/ #198	B/T 2003-2004	Baghdad, Mosul, Balad hospitals	These five individuals, assigned to CSHs, reported a concern that nurses and enlisted medical personnel were required to guard individual detainee patients or wards of detainee patients. Their concerns were for inappropriate use of medical resources and a possible conflict of interest, respectively.
OIF - RE-USE OF SUPPLIES				
48. Re-use of chest tubes	NY Times 04 Feb 05 (Cit. 36)/ Time Mag 07 Feb 05 (Cit. 47). Interview #916/#771	B/T Mar-Jul 04	Abu Ghraib	(b)(2)-2 Regarding the scarcity of supplies, #916 stated that the medical chests had only 6.5 and 9 ET tubes and that they were missing sizes 7, 7.5 and 8. During the MASCAL, there were no sterile chest tubes left. He said he was offered what appeared to be a bloody chest tube; it was rinsed in normal saline and used immediately. He also states that the article misrepresents the care provided to detainees and that top quality care was delivered given the limited resources. #771 states disposable medical supplies were never re-used and he never observed a chest tube being pulled out of one patient and put in another patient.
49. Re-use of expendable medical supplies	Interview # 169	B/T Mar 03-Feb 04	Baghdad	#169 reported that resources were available but observed sharing of needles and sharing of drugs for all Iraqi patients. There was fear that medical supplies would be depleted. Assigned to (b)(2)-2
50. Re-use of supplies	Interview #634	B/T Mar 03-Feb 04	Baghdad/ Tikrit	"Did not have policy on re-use of expendable medical supplies, but had direction that scope of care in Iraq would permit that, and policy from higher HQ was to care for Iraqis based on local scope of care. Did Commander's Inquiry concerning the re-use of medical supplies and found the allegation was not substantiated." Assigned to (b)(2)-2
51. Re-use of supplies	Interview #197	B/T Nov 03-Jan 04	Baghdad	"Had limited resources. Shared resources equally. Many disposable supplies reused." Because US and coalition forces were evacuated quickly the reuse was mainly limited to the detainees. There was no policy on reuse for Iraqi patients, it was just done because of a shortage of supplies. Assigned to (b)(2)-2
52. Re-use of supplies	Interview #124	B/T May 03-Jul 04	Baghdad	While assigned to the (b)(2)-2 reused syringes with a new needle for Iraqi personnel and detainees.
53. Limited resources/re-use of supplies	Interview #316	B/T Mar 03-Feb 04	Baghdad	"Initially short on supplies. Reused gloves, needles, and syringes on detainees only because of shortage. Always reused on same patient. Did this for three months. As more supplies arrived, stopped the practice."
54. Limited resources/ re-use of supplies	Interview #198	B/T Jan-Jun 03	Tallil	Nurses issued one needle, one syringe, and one pair of gloves per day for mixing drugs, not for patient care. Assigned to (b)(2)-2
55. Re-use of expendable medical supplies	Interview #511	B/T Mar-Jun 03	Tallil Air Base	Reuse of expendable medical supplies for all patients. "We were only allowed to use one pair of gloves per day so we wouldn't run out." Attached to (b)(2)-2

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
OIF - SUPPLY SHORTAGES				
56. Med resources for detainees	Interview #775	B/T Jan 04-Jan 05	Mosul, Tikrit, TF OASIS	# 775 (Commander (b)(2)-2 stated that she "went to (b)(2)-2 for staff and resources, told to provide local scope of care for Iraqis, and to not call them EPWs because detainees did not have to receive the same care per Geneva Conventions."
57. Shortage of medical supplies	NY Times 04 Feb05 (Cit. 36)/ Time Mag 07 Feb 05 (Cit. 47). Interviews #917/#705/ #916/#700	B/T Jul 03-Jul 04	Abu Ghraib	#917 reported a three month lag from ordering to acquiring supplies. There were not enough test strips to monitor blood glucose levels adequately. As a result, the therapeutic goal was limited to keeping blood glucoses in the 200-300 mg/dl range. #705 reported that he did not have adequate supplies and personnel to manage detainee care. (b)(2)-2 01 Mar 04-July 04: #916 commented that (b)(2)-2 should have been better resourced. He stressed that 130 patients were treated in six hours with the staff and supplies available during a MASCAL.
58. Shortage of medical supplies	Interview #139, 137	B/T Mar 03-Mar 04	Kirkuk	#139 and #137 reported that the maneuver unit Bde Commander required one patient to stay at the FST for 3 weeks for intelligence reasons. The patient had significant injuries requiring a great deal of personnel and supply resources. #139 and #137 felt that this was an inappropriate use of FST resources, which were depleted due to holding patients at the FST longer than doctrinally described. #139 and #137 reported that a surgeon from the FST voiced his concerns directly with the Bde commander and the detainee was transferred to a CSH.
59. Shortage of medical supplies	Interview #172	B/T Mar-May 03	BIAP (HVD facility)	#172 reported that initially the facility did not have any clothing for the detainees. #172 reported that he deployed with adequate supplies, but ran out quickly and re-supply was not adequate until about June 2003. #172 reports getting into arguments with the ASMC Commander about the detainee population and that he ultimately threatened involving the ICRC to get the Company Commander to respond to his requests for the needed supplies.
60. Shortage of medical supplies	Interview #95	B/T Apr-Nov 03	Bucca	#95 (combat medic) (b)(2)-2 reported that the MTOE for his unit's medical supplies was inadequate. #95 reported that the only medical supplies he was allowed to deploy with were those on the MTOE and included only his aid bag and no medications (not even Tylenol). #95 felt the packing list for the aid bag was inadequate. #95 reported that he and the other medic in his unit were told by their company that they would always be with a hospital and have medical supplies provided to them in theater. #95 stated that he used all of the resources he had on the detainees and did not have enough for US soldiers at times. Before Dec 2003, #95 had to drive to Kuwait to pick up supplies for US soldiers and detainees.
61. Shortage of medical supplies	Interview #713	B/T Mar 03-Jul 04	Balad	#713 rated detainee medical supplies as poor to none. He received directives to use resources on US soldiers first and only use what was left over for detainees. He formally requested a separate source of supplies for detainees. He felt that as medics, they were put in an unfair position because they weren't given enough to care for both US soldiers and the detainees, and yet they were held accountable to the ICRC for the care given to the detainees.
62. Shortage of medical supplies	Interview #683	B/T Jan-Jun 04	Baghdad	#683, assigned to (b)(2)-2 reported making specific requests to (b)(2)-2 including specialized orthopedic and neurosurgical supplies, that would result in more definitive surgical results and shorter length of stay for detainees. (US soldiers with these surgical requirements were evacuated out of theater, which is why the CSH didn't deploy with these items initially.) He felt the (b)(2)-2 (b)(2)-2 really did want to help, but that they possibly didn't know how to accomplish these special requests. Ultimately, these supplies were made available to them after a more experienced MSC Logistician was provided to the (b)(2)-2
63. Inadequate instrumentation to treat maxillofacial injuries	Interview #692	2003		#692 reported there were detainees with maxillofacial injuries that required plates and screws that were not available. #692 attempted to procure the items prior to and during deployment without success. However, the unit that followed did receive these items.
64. Shortage of medical supplies	Interviews #261/708	B/T Mar-Jun 03	Baghdad, Kuwait	#261 (b)(2)-2 and #708 (b)(2)-2 reported that the medical re-supply system in theater was not adequate because the supply routes would "go down."
65. Shortage of medical supplies	Interview #770	B/T Feb-May 03	Objective RAMS	Ethics committee of (b)(2)-2 met to discuss if the unit should hold back supplies for US soldiers. The ethics committee decided all patients would get the same treatment and have equal access to resources.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
66. Inadequate resources for detainee care	Interview #773	B/T Feb 03-Feb 04	Baghdad	#773 (medical planner, (b)(2)-2 office) reported that he received no guidance from CFLCC or CENTCOM that addressed detainee medical care. Planning at (b)(2)-2 level began in Apr 02. There was discussion and planning for detainee medical care but the terminology used was "displaced civilians" or "EPW," and never the term "detainees." In going to the compressed deployment, #773 stated there was no time to get additional hospitals in theater. #773 reported that the (b)(2)-2 intent was to evacuate the displaced civilians or EPWs back to Kuwait for medical care. #773 reported that, during the planning stages, it was not known that Iraqis would not be able to be taken out of Iraq.
67. Inadequate medication supply for detainees	Interview #512	B/T Apr 03-Apr 04	Camp Scania	#512 (b)(2)-2 reported they had a shortage of medication for all of their patients, including azithromycin and cold medications, and some medications specifically needed for detainees, including insulin and cardiac meds.
68. Shortage of medical supplies	Interview #293	B/T Apr 03-Mar 04	Baghdad	#293 (b)(2)-2 stated that "some medical supplies were limited at our level. I trained my Soldiers to treat US Soldiers first. If supplies were available, then we treated all the same."
69. Shortage of medical supplies	Interview #978	B/T Apr 03-Apr 04	BIAP	#978 (b)(2)-2 stated that medication supplies for diabetic and insulin-dependent diabetic patients was limited. #978 felt that the supporting MP units could not procure the necessary medications through logistic channels.
OIF - DETAINEE ENVIRONMENT				
70. Inadequate detainee environment	Interview #511	B/T Mar-Jun 03	Tallil Air Base	#511 (b)(2)-2 reported that there were not enough blankets for the detainees at night in the ICW and that it was very cold there. #511 was not supplied with extra blankets despite requests. #511 suggested to "his COL" that he was going to build a fire in the middle of the ICW to keep the patients warmer. He was told not to build a fire and blankets were then provided.
71. Inadequate detainee environment	Interview #444	B/T Apr 03-Apr 04	Abu Ghraib	#444 (combat medic (b)(2)-2 reported that Abu Ghraib sanitation was poor and that, in addition, the food supply for the detainees was horrible. He found cockroaches in the food that was available for the detainees and he dumped it out himself so it could not be served to them and they were given MREs instead. He stated that he reported his concerns directly to the (b)(2)-2 Bde Commander and complained about this constantly, but it never got better while he was there. He also reported having policies briefed to him about not giving medical care or appropriate food or sanitation to the detainees. He stated that he and the other medic from his unit did not follow these policies and that he was formally reprimanded at least five times as a result. He reported issue to (b)(2)-2 Bde Commander directly; no actions taken.
OIF - POTENTIAL ABUSES-BY US/COALITION FORCES				
72. Performing medical procedure on dead Iraqi soldier	Interviews #2/#704/ #701/#249 /#642 and Team member telecon with CDR, (b)(2)-2 (b)(2)-2 18 Mar 05	Sep-03	Camp Ramadi	A dead Iraqi was brought to the (b)(2)-2 aid station. He was placed in a body bag and removed from the aid station. A physician went out to view the body and performed a cricothyroidotomy, inserted a tube, and instructed medics on how to perform the procedure. 15-6 was done. The physician received a GO letter of reprimand. This incident was referred by the Team to CID.
73. Criminal detainee on a leash	NY Times 04 Feb 05 (Cit. 36)/ Time Mag 07 Feb 05 (Cit. 47). /Interview #705/#917/ #974	B/T Jul 03-Mar 04	Abu Ghraib	#705 (b)(2)-2 stated he never directed the MPs to use a leash. #705 felt that he ran out of options to control a mentally unstable criminal detainee. He pursued transfer to the (b)(2)-2 and to a civilian Iraqi hospital with mental health services, but both refused. #705 determined that the only remaining option was to apply a belt around his abdomen as a temporary measure. The belt ended up around his neck. #705 does not how this happened. The detainee was being restrained for throwing feces and self-mutilation. #705 worked with the NCOIC of (b)(2)-2 to order a harness, but could not locate one in the automated supply system. #917 stated restraint was applied only to one other detainee for the purpose of administering IV fluids. #917 reported that the MPs did not use restraints because it required additional personnel to monitor. #705 stated that he was misrepresented in the New York Times article.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
74. Beating of an Iraqi born American by Special Forces when he stood in the way to prevent the rape of a local Iraqi girl.	Interview #695	B/T Jul-Oct 03	BIAP	#695 recalls an incident that was described to him by an Iraqi-born American citizen on a mission with the Special Forces. He stated the Special Forces attempted to rape a local Iraqi girl. When the Iraqi-born American citizen stood in the way, he was beaten and presented to #695 for treatment. #695 reported this incident to CID for investigation.
75. Abuse of a detainee by MP	Interview #695	B/T Jul-Oct 03	BIAP	A material witness, kept as a detainee for his own protection, was used as an interpreter. He was handcuffed and dragged to a transportation vehicle by an MP. When another interpreter appeared, the MP denied the abuse. The interviewee reported the incident to CID for investigation.
76. Detainee with burns	Interview #734	B/T Jan-Mar 04	Abu Ghraib	#734 documented injuries consistent with abuse (cigarette burns) during initial screening of a detainee. As he had early access to the detainee upon arrival to the facility, #734 felt the abuse must have been done by the capturing unit. #734 submitted photographs and sworn statements to the Abu Ghraib CID. #734 was told by Abu Ghraib CID that if incidents occurred outside of Abu Ghraib it was not in their jurisdiction and the reports would be passed on to a higher level of CID whenever that other CID unit passed thru Abu Ghraib. #734 felt this was inadequate and went to the FOB Commander for guidance. The FOB Commander and #734 decided to turn these reports over to CID, ICRC, and the Coalition Provisional Authority to ensure they would be investigated fully.
77. Detainee death	Interview #475	B/T Jun 03-Mar 04	Balad/ Mosul	#475 had to report a potential detainee abuse case to CID three times before it was fully investigated. Ultimately, a soldier was arrested for the abuse incident
78. Detainee abuse	Interview #458	B/T Jun-Oct 04	Balad	#458 reported that an "MP on ward was found guilty of abuse and demoted."
79. Detainees with burns	Interview # 172/#206/# 209/# 634 and (b)(2)-2 (b)(2)-2 Medical Record Review (Detainee register # 0013753, #0015835)	B/T Mar-Aug 03	Camp Cropper	#172 saw many injuries that he suspected were from abuse. He reported each of these, officially, to CID and to the Warrant Officer who was designated to receive abuse allegations. The reports he submitted included two patients with burns on their buttocks from being transported in a High Mobility Multi-Wheeled Vehicle (HMMWV) while seated on a hot surface. In reviewing the medical records from the (b)(2)-2 #172 documented his findings, his concern for abuse, and his contacting CID (register # (b)(7)(C)-4 and in his interview he states he reported register # (b)(7)(C)-4 as well).
80. Abuse of a detainee by US soldiers	Interview #80	Jul-04	Bucca	#80 stated that a detainee reported he was dragged by chains around the compound by a HMMWV. #80 involved his supervising physician, who documented a history and physical exam and took a sworn statement. #80 reported that this physician reported the incident up the chain of command.
81. Detainee abuse	Interview #221	B/T Aug 03-Apr 04	Fallujah.	#221 recalled an incident that occurred after the hospital was bombed and two health care providers were killed. #221 reported that a medic got angry and hit a detainee. This was handled by the medic's unit (b)(2)-2 with formal counseling of the medic.
82. Detainee with multiple bruises	Interview #385/#386	B/T Aug 03-Apr 04	Fallujah	Detainee had repeatedly attempted escape, had multiple bruises; 15-6 done, and charges unsubstantiated.
83. Possible detainee abuse	Interview #765	B/T Jan -Oct 04	Baghdad	#765 reported that a soldier was transporting a detainee when a improvised explosive device exploded, injuring personnel in the HMMWV. The soldier got mad, went to the back of the convoy and hit a detainee. This was reported to, and investigated by, CID.
84. Detainee found unresponsive	Interview #246	Spring 03	Baghdad	Patient in ketoacisosis, but MPs approached as if he were merely faking. Reported up chain of command and investigated; patient treated successfully for critical illness.
85. Detainee "kidnapped" from FST by MI	Interview #246	Spring 03	Baghdad	Event reported up chain of command and investigated; patient returned and treated appropriately.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
86. Detainee beaten by MPs excessively after attempted escape from holding facility	Interview #246	Spring 03	Baghdad	Event reported up chain of command and investigated; patient hospitalized and treated.
87. Detainees with suspicious injuries	Interview #209	B/T Mar 03-Feb 04	Baghdad	One patient with bruises, another with burns. Chain of command/CID notified.
88. Detainees with burns	Interview #206	B/T Mar 03-Feb 04	Baghdad	Reported for investigation; confirmed with other interview and med records review.
89. Possible detainee abuse	Interview #634	B/T Mar 03-Feb 04	Baghdad/ Tikrit	At the (b)(2)-2 a detainee was brought in with suspected abuse; gentleman came with abrasions to his lower legs, feet and ankles, consistent with being drug around. It was reported by doctor, to DCCS, to med CINC meeting (detainee camps and special ops, directing medical assets) at Mosul.
90. Detainee DOA with multiple bruises	Interview #206	B/T Mar 03-Feb 04	Baghdad	Not clear if bruises related to point of capture, but reported thru chain of command for investigation.
91. Detainee with multiple bruises including boot print to axilla	Interview #581	B/T May 03-Jul 04	Baghdad	Reported thru chain of command to CID.
92. Detainee abuse	Interview #775	B/T Jan 04-Jan 05	Mosul, Tikrit, TF OASIS	#775 referred three cases to CID. "I met with CID Commander and was informed that all the cases had been investigated."
93. Detainees forced to stand bound on blacktop all day. They went hours without water. At least two fainted.	Interview #72	B/T Jan-Aug 03	In vicinity of aid station.	Not reported by soldier, who was assigned to (b)(2)-2 Team referred incident to CID.
94. Detainee handcuffed to a vehicle steering wheel	Interview #545	B/T May-Jun 03	Baghdad/ Najef	Reported to COC. A Platoon Leader, assigned to (b)(2)-2 left the detainee handcuffed for at least five hours in an awkward position; detainee became ill. Platoon Leader was subsequently reprimanded and apologized to the patrol.
95. Detainee abuse	Interview #470	B/T Jan-Jun 03	Camp Bucca	Psychotic detainees were being held in Connexes in 130 degree temperatures, lying in own urine and feces. Reported to Camp Bucca Leadership; conditions corrected.
96. Detainee Abuse	Interview #492	B/T May-Sep 03	Camp Victory	Guards reported that MI personnel had placed handcuffed detainees outside in 120+ degree temperatures for nine hours. Two detainees treated for heat injuries. Interviewee confronted MI First Sergeant, reported to (b)(2)-2 and sent written report to MP Battalion Commander.
97. Possible detainee abuse	Interview #715	B/T Mar 03-Feb 04	Mosul	Detainee with injuries not consistent with falling (guard's story), but with assault. Referred to CID.
98. Detainee abuse	Interview #625	B/T Jan 04-Jan 05	Unknown	US Soldier injured in convoy ambush hit a detainee. Reported and investigated.
99. Possible detainee abuse	Interview #96	B/T Jan-Jun 03	Tallil	Detainee had been very combative, and had attempted multiple escapes. Reported to chain of command; formal investigations done, and not substantiated.
100. Possible detainee abuse	Interview #380	B/T Apr 03-May 04	Fallujah	Detainee complained of abuse frequently; referred for investigation, and unsubstantiated.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
101. Possible abuse of Iraqi firefighter	Interview #380	B/T Apr 03-May 04	Fallujah	Report of a Company Commander physically abusing an Iraqi firefighter; CID notified and investigated.
102. Detainee abuse	Interview #38	B/T May 03-Mar 04	Baghdad	Detainee reported abuse, investigated. "Commander relieved, appropriate action taken."
103a. Possible detainee abuse	Interview #200	B/T Mar 03-Feb 04	Mosul	One detainee brought in with broken jaw. Detainee said he was pushed, MP said he fell. This occurred as detainees were made to exercise, doing squats while wearing hoods. Once guidance was changed concerning detainee operations, stopped using loud music and prolonged standing activities.
103b. Detainee death	Interview #200	B/T Mar 03-Feb 04	Mosul	A detainee with diabetes and hypertension died. Did not do an autopsy. Death was investigated by CID. Interviewee reported the investigation did not "show anything."
104. Possible detainee abuse	Interview #549	B/T Dec 03-Jul 04	Baghdad	Detainee reported abuse, did full exam and x-rays; investigated; abuse unfounded.
105. Detainee abuse	Interview #572	B/T May 03-Aug 04	Baghdad	Individual physically abused a detainee and he was chaptered out of the Army.
106. Possible detainee abuse	Interview #788	B/T Jan-Mar 05	Abu Ghraib	Detainee alleged abuse during interrogation; post-interrogation record did not reflect abuse reported at that time. Detainee brought to ER, CID notified; detainee retracted allegation.
107. Documentation of pre-interrogation screening in detainee record; detainees presenting with old injuries; MPs yelling at detainees	Interview #978	B/T Apr 03-Apr 04	BIAP	Assigned at BIAP and worked at the DIF; prisoners would show up at (b)(2)-2 with MP without coordination; felt that some of the MPs yelled at detainees and did not have a good understanding of cultural considerations; language barrier exacerbated the event. A number of detainees came in with injuries (approximately five days old); wounds were infected. #978 brought this up to the physicians. Physicians and medics would clarify the nature of the injuries through the interpreter (assigned w/ MP). On two occasions, #978 questioned the nature of the injury to the MP. MP said facial injuries occurred from another Iraqi civilian.
108. Two cases of possible detainee abuse observed	Interview #132/#133	B/T Apr-Dec 03	BIAP	Documented in medical record, took pictures, and forwarded through chain of command for investigation.
109. Detainees placed in metal guard shack	Interview #599	B/T May 03-May 04	Baghdad	Observed detainees placed in guard shack that was very hot, handcuffed, with sandbag over the head. No injuries sustained by detainees.
110. Rumor of a soldier using a tazor on a detainee	Interview # 850	B/T May 03-Jul 04	Baghdad	Reported as a rumor only; not mentioned in 61 other interviews with individuals from (b)(2)-2
111. Physician refusing to treat a detainee.	Fay/Jones report/ Interview #897/#904/ e-mail correspondence to Team	Dec-03	Abu Ghraib	An MI soldier, in her testimony for the Fay /Jones report, stated that she found a detainee in his cell with a Foley catheter in place but without a collection bag attached. She stated that she contacted the physician on duty that night and he refused to see the patient or attend to her concerns. The Team contacted the MI Soldier to get more information about who this physician was. She did not remember his name, nor remember if he was a LTC or a COL, but stated that she could identify him in a picture if given one. The Team spoke to many medics and the few physicians that were working in Abu Ghraib around the time of this incident. The Team was not able to identify this physician. #970 does not meet the description and #706 re-deployed November 03, per email msg dated 25 Mar 05 to Team member.
112. Detainees held in inappropriate environment	Interview #574	B/T Jul 03-Jul 04	Baghdad	The detainees were held in a large pen without cover, hands were bound, and 90% of the time they had sandbags over their heads. The detainees were not treated with dignity and respect. Sometimes made to stand for two hours at a time.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
OIF - POTENTIAL ABUSES-BY IRAQIS/IRAQI POLICE				
113. Sexual assault of a possible child detainee (age unknown) by another prisoner	Interview #970	B/T Oct 03-Mar 04	Abu Ghraib	An interpreter reported to #970, assigned to (b)(2)-2 that a detainee, believed to be a child detainee, had been sexually assaulted by another prisoner. #970 reported it to the (b)(2)-2 Commander, who investigated. #970 believes the criminal detainee was disciplined through the Iraqi court system. Afterwards, no children were sent to Abu Ghraib.
114. Possible sexual abuse of detainees	Interview #711	B/T Jan 04-Jan 05	Baghdad	#711, assigned to (b)(2)-2 reported that the unit received assistance in the investigation of two episodes of alleged sodomy on detainees. In both instances, the MP physician made the initial reports at the detention facility. This was reported to (b)(2)-2 and they contacted the (b)(2)-2 to accept the patients in transfer for further evaluation. Both had colonoscopies done to evaluate for physical findings that supported this allegation. CID was involved immediately to collect statements and medical records and investigate this further. In a third episode, #711 was concerned about abuse and when he reported it, CID came three weeks later to the (b)(2)-2 to gather information for their investigation.
115. Abuse of detainees by Iraqi police.	Interview #37	B/T Apr-Oct 04	Northwest Iraq	This physician reported that, at his BAS, they treated numerous detainees that had been physically abused by the Iraqi police. In order to prevent this further, the US MPs took custody of the detainees after their medical treatment.
116. Detainee with bruises	Interview #385	B/T Aug 03-Apr 04	Fallujah	Investigated and found to be from other Iraqis.
117. Detainee abused by other Iraqis--SQ injections with gasoline	Interview #804/#775	B/T Jan 04-Jan 05	Mosul	CID notified; no adverse clinical outcome.
118. Physical abuse of a detainee by Iraqi Army at a detention facility	Interview #816	Early 2005	Baghdad	Chain of command notified; practice stopped.
119. Sexual assault of a young detainee	Interview #915	B/T Mar-Jun 03	Balad	Young detainee gang-raped twice in holding facility, second time after being returned to same area. MPs had no guards assigned directly within the facility. Unclear if any actions taken.

Chapter 21
Citations in the Report

1.	AMEDDC&S 91W10 Lesson Plan - International Humanitarian Law and the Geneva Conventions (DRAFT) - 30 Mar 2005.
2.	AMEDDC&S Exportable Training Package – Ethics and Detainee Operations - 2005.
3.	AMEDDC&S Email - Exportable Training Package – 24 Mar 2005.
4.	AMEDDC&S PAD - Just-in-Time Deployment Training – 10 Apr 2004.
5.	AMEDDC&S PAD - Medical Documents in Combat and Contingency Operations – 10 Apr 2004.
6.	AMEDDC&S - Review of Institutional Training – 15 Feb 2005 and AMEDDC&S Courses.
7.	AMEDDC&S Training Materials.
8.	AR 40-3 - Medical, Dental, and Veterinary Care – 12 Nov 2002.
9.	AR 40-66 - Medical Record Administration and Health Care Administration – 20 Jul 2004.
10.	AR 40-400 - Patient Administration – 12 Mar 2001.
11.	AR 190-8 - Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees – 1 Oct 1997.
12.	Bagram SOP, Annex W-1 - Sep 2004.
13.	Behavioral Science Consultation Team Joint Intelligence Group, Joint Task Force-GTMO Standard Operating Procedures – 28 Mar 2005.
14.	Bucca SOP, sec. 4-4: Detainee Medical Procedures - Jun 2004.
15.	Church – Comprehensive Review of Department of Defense (DoD) Interrogation Operations – date unknown.
16.	CJCSI 3290.01A - Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel (EPW/Detainee Policy) -15 Oct 2000.
17.	CJTF-76 BHA and KHA Detainee Medical Standard Operating Procedure (SOP) - August 2004.
18.	CONOPS for DHT in Support of Military Intelligence Interrogation Operations.
19.	DAIG – Detainee Operations Inspection Report – 21 Jul 2004.

20.	Deputy Secretary of Defense Memorandum, Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees under DoD Control – Jan 2005.
21.	DoD Instruction 1322.24 - Medical Readiness Training – 12 Jul 2002.
22.	DoD Directive 2310.1 - DoD Program for Enemy Prisoners of War and other Detainees – 12 Aug 1994.
23.	DoD Directive 5100.77 - DoD Law of War Program - 9 Dec 1998.
24.	Email – (b)(6)-2 – More Questions About the Catheter - 28 Mar 2005.
25.	Fay/Jones – Article 15-6 Investigation of the Abu Ghraib Prison and 205th Military Intelligence Brigade – Feb 2004.
26.	GTMO - Numerous theater-level/facility policies for detainee medical operations since early 2003.
27.	GTMO - Numerous SOPs from the Detainee Hospital, GTMO, from 2003 and 2004.
28.	Health Affairs Policy 02-005: DoD Medical Care for Enemy Persons Under U.S. Control Detained in Conjunction with Operation Enduring Freedom, 10 Apr 2002.
29.	Jacoby - Review of Detainee Operations and Facilities in Afghanistan – 26 Jul 2004.
30.	Lancet (Miles) - The Legacy of Abu Ghraib – 21 Aug 2004.
31.	MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 2004.
32.	MEDCOM - Deployment Medical Documentation Guidance-Reporting Requirements – 12 Mar 2004.
33.	MEDCOM SJA - Health Care Professional Detainee Abuse Reporting Requirements – 8 Sep 2004.
34.	MNF-I SOP: Detainee Healthcare – Feb 2005.
35.	NEJM (Lifton) - Human Rights - Doctors and Torture – 29 Jul 2004.
36.	New York Times (Bloche & Marks) - Triage at Abu Ghraib – 4 Feb 2004.
37.	OIF Theater Detention Healthcare Policy – Jan 2005, with multiple appendices.
38.	Physicians for Human Rights – Examining Asylum Seekers.
39.	Ryder – Assessment of Detention and Corrections Operations in Iraq – 6 Nov 2003.

40.	Schlesinger – DoD Detention Operations Final Report – Aug 2004.
41.	Secretary of Defense Memorandum: Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the U.S., 9 Jun 2004.
42.	SOUTHCOM Confidentiality Policy for Interactions between Health Care Providers and Enemy Persons under U.S. Control, Detained in Conjunction with OEF – August 2002.
43.	SOUTHCOM Policy on Healthcare Delivery to Enemy Persons under U.S. Control at US Naval Base, Guantanamo Bay, Cuba – Aug 2004.
44.	Taguba – Administrative Investigation of Alleged Detainee Abuse by the 800th Military Police Brigade – 24 Jan to 9 Mar 2004.
45.	Task Force Medical 115 Poster and Soldier Cards: "Tenets of Detention Healthcare" – Mar 2005.
46.	Task Force 134 Memorandum, SOP for Ensuring Separation of Detention Operations Functions – Feb 2005.
47.	Time Magazine (Zagorin) - The Abu Ghraib Scandal You Don't Know – 7 Feb 2005.
48.	104 DIV PPT - Process EPW/CI at a Collection Point or Holding Area – date unknown.

Chapter 22
Glossary of Terms

ABBREVIATIONS	TERM
AAR	After Action Review
AC	Active Component
AIT	Advanced Individual Training
AKO	Army Knowledge On-Line
AMEDD	Army Medical Department
AMEDD C&S	Army Medical Department Center and School
AOC	Area of Concentration
AOR	Area of Responsibility
AR	Army Regulation
ASMB	Area Support Medical Battalion
ASMC	Area Support Medical Company
AT	Annual Training
BAS	Battalion Aid Station
BDE/Bde	Brigade
BIAP	Baghdad International Airport
BIF	Brigade Internment Facility
BN/Bn	Battalion
BSCT	Behavioral Science Consultation Team
CENTCOM	Central Command
CF	Coalition Forces
CFLCC	Combined Forces Land Component Command
CI	Civilian Internee
CID	Criminal Investigation Division
CJTF	Combined Joint Task Force
CLS	Combat Lifesaver
COB	Civilians on the Battlefield
COD	Cause of Death
CONOPS	Concept of Operations
CONUS	Continental United States
CPA	Coalition Provisional Authority
CRC	CONUS Replacement Center
CSA	Chief of Staff-Army
CSC	Combat Stress Control
CSH	Combat Support Hospital
CSS	Combat Service Support
CTT	Common Task Training
C2	Command and Control
DA	Department of the Army
DAIG	Department of the Army Inspector General
DHT	Detainee Health Team
DIF	Division Internment Facility

DoD	Department of Defense
EFMB	Expert Field Medical Badge
EPW	Enemy Prisoner of War
EMEDS	Expeditionary Medical Support
EXSUM	Executive Summary
FH	Field Hospital
Fm	Field Manual
FOB	Forward Operating Base
FORSCOM	Forces Command
FRAGO	Fragmentary Order
FSB	Forward Support Battalion
FST	Forward Surgical Team
FTX	Field Training Exercise
GH	General Hospital
GO	General Officer
GTMO	Guantanamo Bay
HA	Health Affairs
HQ	Headquarters
HVD	High Value Detainee
IAT	Incidents and Allegations Table
IAW	In Accordance With
ICRC	International Committee of the Red Cross
ICW	Intermediate Care Ward
IED	Improvised Explosive Device
I/R	Internment/Resettlement
ITO	Iraqi Theater of Operations
JAG	Judge Advocate General Officer
JIDC	Joint Interrogation and Debriefing Center
JIG	Joint Interrogation Group
JRTC	Joint Readiness Training Center
JTF	Joint Task Force
KIA	Killed in Action
LP	Lesson Plan
LRMC	Landstuhl Regional Medical Center
LTP	Leader Training Plan
LZ	Landing Zone
MASCAL	Mass Casualty
MED/Med	Medical
MEDCOM	Medical Command
METL	Mission Essential Task List
MEU	Marine Expeditionary Unit
MI	Military Intelligence
MNC-I	Multi-National Corps-Iraq
MNF-I	Multi-National Forces-Iraq
MOB	Mobilization

MOS	Military Occupational Specialty
MP	Military Police
MRE	Meals Ready to Eat
MSC	Medical Service Corp
MTF	Medical Treatment Facility
MUIC	Mobilized Unit In-Processing Center
NCOIC	Noncommissioned Officer in Charge
NG	National Guard
NTC	National Training Center
OBC	Officer Basic Course
OC	Observer-Controller
OEF	Operation Enduring Freedom
OGA	Other Government Agency (can refer to CIA, FBI, etc)
OIC	Officer in Charge
OIF	Operation Iraqi Freedom
OPFOR	Opposing Forces
OPORDER	Operation Order
OTC	Over the counter
PA	Physician Assistant
PAD	Patient Administration Division
PASBA	Patient Administration Systems and Biostatistics Activity
POI	Program of Instruction
PPP	Power Projection Platform
PUC	Person Under Control
RC	Reserve Component (Army Reserve or National Guard)
RIP	Relief in Place
ROC	Rules of Care
ROE	Rules of Engagement
RP	Retained Personnel
SD	Security Detainee
SDARNG	South Dakota Army National Guard
SECDEF	Secretary of Defense
SME	Subject Matter Expert
SOC	Special Operations Command (can refer to SF, Delta Force, etc)
SOP	Standard Operating Procedure
SOUTHCOM	Southern Command
STARTEX	Start of Exercise
TACSOP	Tactical Standard Operating Procedure
TB	Tuberculosis
TDA	Table of Distribution and Allowances
TF	Task Force
TIF	Theater Internment Facility
TOA	Transfer of Authority
TOE	Table of Organization and Equipment
TSG	The Surgeon General (refers to the Army Surgeon General)

TTP	Tactics, Techniques and Procedures
USARCENT	US Army Central Command
USARSO	US Army South
VTC	Video Training Conference
XO	Executive Officer

PHRASES	**TERM**
Abu Ghraib	Detention facility located near Baghdad. Site of abuse scandal involving MP and MI personnel. Currently houses a Level III detention medical facility. Has a large detainee population. There is variety in the spelling of this location in the documents cited. The Team, for uniformity purposes, has decided on the spelling listed.
Abuse	Fay/Jones EXSUM page 3 – Treatment of detainees that violated U.S. criminal law or international law that was inhumane or coercive without lawful justification.
AMEDD Center and School	Headquartered at Ft Sam Houston, TX, it is the location where the vast majority of medical training in the Army takes place. It is responsible for Career Management Field 91 (Health Services) schools. It is the site of advanced training for Medical Officers and Medical NCOs. Also trains many members from the other services.
AR 190-8	Army Regulation titled Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Internees, dated 1 October 1997.
Bagram Holding Area	Largest holding area in the OEF theater. It is located at Bagram Air Base. For the purpose of this report it is considered a detention facility.
Brigade Detention Facility	Detention facility run by a Brigade-level unit that serves as a staging point for detainees before release or transfer to a DIF. Length of stay is very minimal. There are numerous BIFs in the OIF theater.
Camp Bucca	Largest of detention facilities. Houses a Level III detention medical facility.
Camp Cropper	Detention Facility located at BIAP. Houses a Level II detention medical facility.
Career Captains Course	Course designed for commissioned officers with a medical AOC at the 1LT-CPT level. Formally called the Officer Advanced Course.
Chain of Command	Succession of leadership from squad leader to President of the United States.
Combat Life Saver	Non-medical personnel trained to perform basic life saving procedures in emergency situations,
CONUS Replacement Centers (CRC)	Specific locations designed to prepare, assess and give final approval to individuals headed to units in a theater of operations. The two stateside CRCs are located at Ft Bliss and Ft Benning.

Detainee	Term used for any person under US/Coalition control in the three theaters highlighted in this report. Includes enemy prisoners of war, civilian internees, retained personnel, high value detainees, security detainees and persons under control.
Detainee Care	Medical care given to any persons under US/Coalition custody.
Detainee Caregiver	Any medical personnel who provided medical care to at least one detainee during their tour in theater (OEF, GTMO, OIF).
Detainee Medical Records	Medical documentation of inpatient and outpatient treatment and care given to personnel under US/Coalition control.
Detention Facility	Refers to any area where a detainee is maintained, processed, interrogated or all of the above. This report focuses on division-level detention facilities and above.
Division Internment Facility	Detention facility located in theater that serves as a staging point for detainees before release or transfer to a fixed prison facility. Time of stay for detainees is up to 21 days, 28 days with GO approval.
15-6 Investigation	Official investigation started at the direction of the unit, or higher, command.
High Value Detainee	Any detainee who may hold significant information on enemy operations in the OIF/OEF theater. Also refers to prominent members of the former Iraqi Regime.
Home Station	Military installation where a military member is stationed before mobilizing for deployment.
Kandahar Holding Area	Holding area located at Kandahar Air Base in the OEF theater. For the purpose of this report it is considered a detention facility.
Levels of Medical Care	Refers to the capabilities a medical unit has to perform medical services. Level I includes self-aid, buddy-aid, Combat Life Savers, Line Unit 91Ws (Medical Specialists) and Battalion Aid Stations. Level II includes Forward Surgical Teams and Area Support Medical Battalions. Level III refers to Mobile Surgical Hospitals, Combat Support Hospitals, General Hospitals and Field Hospitals. Note that the levels of care of some units in the OEF and OIF theater significantly changed as resources and personnel were or were not available.
Line Medic	Medical Personnel assigned to a combat arms unit. These medical personnel accompany the combat arms soldiers on all missions in order to be able to perform emergency medicine.
Maneuver Unit	Combatant Unit/Combat Arms Unit
Medical Personnel	Refers to all personnel who hold a medical MOS or AOC.
Mobilization	Occurs in phases, and refers to the actions taken to prepare and deploy a unit.
MP Medic	Medical personnel, usually a 91W, assigned to an MP unit.
91G	Army Medical Records Specialist
91W	Army Healthcare Specialist. Commonly referred to as a combat medic.
91WM6	Army Licensed Practical Nurse

91X	Army Mental Health Specialist
Officer Basic Course	Initial training for commissioned officers with a medical AOC at the 2LT-CPT level.
Operation Enduring Freedom	Refers to actions in the Afghanistan region that began in December of 2001 and is currently ongoing.
Operation Iraqi Freedom	Refers to actions in the Iraq/Kuwait region that began in March 2003 and is currently ongoing.
PASBA	Designated as the repository for all detainee medical records from the OIF and OEF theater.
Period of Service	The time frame a unit or individual was deployed to a Theater of Operations.
Point of Capture	Initial place that a detainee is taken into US/Coalition custody. Normally accomplished by a combat arms unit
Power Projection Platform (PPP)	Specific locations designed to prepare, assess and give final approval to the deployablility of units heading into the different theaters.
Rules of Care	Specific guidelines that detail the actions that medical personnel need to take in treating non-US/Coalition troops in that theater. Often referred to as Medical Rules of Engagement (MROE).
Southern Command	Headquarters, located in Florida, that has command and control over Guantanamo Bay.
S-2	The Security and Intelligence Cell of individual units.
S-3	The Plans and Operations Cell of individual units.
70E	Refers to the AOC given to a Patient Administration Division officer.
Task Force	A grouping of units, or parts of units, brought together to perform a specific mission.
Team (the)	Refers to the Functional Assessment Team, the authors of this report.
Theater	An area of major operations by the US military. This report deals with the Afghanistan, Iraq/Kuwait and Guantanamo Bay theaters. Can also be referred to as a Theater of Operations.
Training Centers	Can refer to a number of military institutions involved in training soldiers. In CONUS, most commonly used to refer to the National Training Center and the Joint Readiness Training Center.
USARSO	The Army Service Component of the US Southern Command, headquartered in San Antonio, TX.

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
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REPLY TO ATTENTION OF

MCJA 12 November 2004

MEMORANDUM FOR Major General Lester Martinez-Lopez, Commanding General, U.S. Army Medical Research and Materiel Command, 504 Scott Street, Ft. Detrick, Maryland 21702

SUBJECT: Appointment as Team Leader, Functional Assessment Team

1. You are hereby appointed as Team Leader of a Medical Training, Operations and Treatment Functional Assessment Team. In this capacity, you will lead the team identified at Enclosure 1 to assess whether Army medical personnel serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) properly generated, stored and collected medical records. You will assess the adequacy of all law of war training for all medical personnel from accession to deployment into the theater of operations in OEF and OIF. In conjunction with your assessment, you should also determine whether any medical personnel observed or became aware of improper treatment of detainees which could be abuse and, if so, whether they properly documented and reported the abuse. Additionally, with respect to medically documenting and reporting detainee abuse, you will also assess both the adequacy of MOS/OBC/other school training, unit training, pre- and post-deployment medical training and the adequacy of medical operations doctrine. You will specifically determine whether the training covered the procedures and policies for maintaining medical records and for providing medical treatment to POWs and other detainees.

2. Specifically, you will assess the following with respect to Army medical personnel, both reserve component and active duty, providing medical support and/or care to detainees in OEF (including Guantanamo Bay) and OIF:

a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?

b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?

c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?

d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?

e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

g. Identify OEF and OIF detention medical facilities.

h. With respect to the detention medical facilities identified in subparagraph 2g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.

i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?

j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.

k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?

l. Did any medical personnel aware of, or who treated actual or suspected detainee abuse properly document the abuse?

m. To who did any medical personnel aware of, or who treated, detainee abuse report such abuse?

n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?

3. Prior to commencing your functional assessment, you and each team member will:

a. Become familiar with the findings and recommendations of existing investigations into detainee abuse (e.g., Schlesinger, Taguba, Fay, Ryder, Miller, Jacoby and Church).

IECT: Appointment as Team Leader, Functional Assessment Team

Rules of Instruction for Functional Assessment Team (Enclosure 2).

, Law of war requirements for medical support and/or care to POWs and other inees.

). Published media articles (newspaper, Internet, periodicals) specifically imenting on medical aspects of detainee abuse (e.g., The Legacy of Abu Ghraib, icet, 21 Aug 04; Doctors and Torture, New England Journal of Medicine, 29 Jul 04; :s Complicit in Prison Abuse?, CBSNEWS.com, 27 Oct 04).

e. Army Chief of Staff Memorandum, SUBJECT: Army Detainee Operations and tainee-Interrogation Operations Integration Plan, dated 17 Sep 04.

f. Army Detainee Operation Synchronization Matrix, Version 2.0 dated 7 Oct 04.

g. Textbook of Military Medicine.

h. Textbook of Emergency War Surgery.

i. Briefing by COL (b)(6)-2 OTSG, to the Senate Armed Services Committee regarding medical treatment to detainees.

j. House Government Reform Committee brief on medical ethics by COL (b)(6)-2 (b)(6)-2 Medical Ethics Consultant and Chief of Medicine, (b)(6)-2

k. Integrated Process Team findings on Policy and Procedures for Medical Detai Operations, charted by MG Farmer, previous DSG, and presented to MG Webb.

4. In drafting your assessment, you should identify the standard (e.g., regulation, policy, field manual, SOP, TTP, OPORDER) used in making your assessment and determine whether medical personnel complied with the standard. You will make recommendations to remediate any deficiencies. If in the course of your assessme you come to suspect that certain people may have committed criminal offenses unc the UCMJ or applicable Federal Statute, you must consult the Rules of Instruction f Functional Assessment Team and follow the instructions set forth therein.

5. Your assessment is not an investigation. Rather you are chartered under the authority of The Surgeon General of the Army to review matters listed in this appointment memorandum and make recommendations. Accordingly, you are no bound by the requirements of the procedures set forth in AR 15-6, rather, you are structions for Functional Assessment Team.

MCJA
SUBJECT: Appointment as Team Leader, Functional Assessment Team

6. This assessment takes precedence over all other normal duties, TDY, leave or other activities. Prior to commencing your duties, you should consult with COL (b)(6)-2 (b)(6)-2 MEDCOM Staff Judge Advocate who may be reached at (b)(6)-2 (b)(6)-2 Once you have commenced your assessment, your legal advisor is LTC (b)(6)-2 who can be contacted at (b)(6)-2 (b)(6)-2 You will regularly consult LTC (b)(6)-2 and you will provide COL (b)(6)-2 a weekly update on the progress of your assessment through LTC (b)(6)-2

7. Once you have concluded your assessment, you will consult with COL (b)(6)-2 before you prepare your report. You will submit your assessment through LTC (b)(6)-2 through COL (b)(6)-2 to me, with appropriate copies, not later than 120 days from the date of this memorandum. If you cannot meet the suspense date, you must request an extension through LTC (b)(6)-2 and COL (b)(6)-2 to me.

2 Encls

KEVIN C. KILEY, M.D.
Lieutenant General
The Surgeon General

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

MCJA

30 November 2004

MEMORANDUM FOR Functional Assessment Team Appointees

SUBJECT: Appointment of Members to Functional Assessment Team

1. The following are hereby appointed as members to the Medical Training, Operations and Treatment Functional Assessment Team:

a. Team Leader: MG Lester Martinez-Lopez, MRMC

b. Legal Advisor: LTC (b)(6)-2 JA, (b)(6)-2

c. COL (b)(6)-2 MS, (b)(6)-2

d. COL (b)(6)-2 MC, (b)(6)-2

e. COL (b)(6)-2 AN, (b)(6)-2

f. MAJ (b)(6)-2 MC, (b)(6)-2

g. SFC (b)(6)-2 91W, (b)(6)-2

2. The team leader exercises authority over your activities as a team member. Your duty as a team member takes precedence over all normal duties, TDY, leave, or other activities.

3. Team members are subject to the limitations set forth in the Rules of Instruction for Functional Assessment Team, which will be distributed by the team leader.

4. Point of contact for this action is COL (b)(6)-2 Staff Judge Advocate, (b)(6)-2 (b)(6)-2

KEVIN C. KILEY, M.D.
Lieutenant General
The Surgeon General

DEPARTMENT OF THE ARMY
HEADQUARTERS
U.S. ARMY MEDICAL RESEARCH AND MATERIEL COMMAND
AND FORT DETRICK
504 SCOTT STREET
FORT DETRICK, MD 21702

REPLY TO
ATTENTION OF:

MCMR-Z

14 December 2004

MEMORANDUM FOR Medical Training, Operations and Treatment Functional Assessment Team

SUBJECT: Appointment as Acting Adjutants

1. Pursuant to paragraph 3-3e of Army Regulation 614-100, the commissioned officers listed in paragraph 2 below are appointed as acting adjutants. This appointment is made for the specific purpose of empowering these officers to administer oaths pursuant to 10 U.S.C. 936(a)(3). This appointment is valid for all actions taken pursuant to their duties as members of the above Functional Assessment Team.

2. The following officers are appointed as acting adjutants:

a. COL (b)(6)-2 MS, (b)(6)-2

b. COL (b)(6)-2 MC, (b)(6)-2

c. COL (b)(6)-2 AN, (b)(6)-2

d. MAJ (b)(6)-2 MC, (b)(6)-2

LESTER MARTINEZ-LOPEZ
Major General, MC
Team Leader

Chapter 24 - Exhibit B
Functional Assessment Team Biosketches

Rank	MG	
Name	Lester Martinez-Lopez	
Branch/MOS	MC	
Current Duty Assignment	USA Medical Research and Materiel Command, Ft Detrick, MD	
Brief History of Previous Assignments	Mar 2002 – Present	Commanding General, USAMRMC, FT Detrick, MD
	Jan 2000 – Mar 2002	Commanding General, USACHPPM, Aberdeen, MD
	Jun 1999 – Jan 2000	Command Surgeon, HQ USA FORSCOM, FT McPherson, GA
	May1998 – Jun 1999	Commander, USA MEDDAC, FT Benning, GA
	Jun 1996 – May 1998	Commander, USA MEDDAC, FT Campbell, KY
	Jul 1994 - Jun1996	Commander, Combat Support Hospital FT Campbell, KY
	Jul 1990 – Jul 1994	Chief of Family Practice Service, USA MEDDAC FT Benning, GA
	Jun 1988 – Jul 1990	Division Surgeon, Infantry Division, FT Carson, CO
	Jul 1985 – Jun 1988	Dispensary Commander, MD DET GEN DISP CP Walker, KS
	Jul 1983 – Jul 1985	Aerospace Medical Resident, STU DET AHS FT Sam Houston, TX
	Oct 1981 – Jul 1983	Flight Surgeon, Family Practice, USA HLTH CLN FT Belvior, VA
	Jul 1979 – Oct 1981	Family Practice Resident, USA MEDDAC FT Bragg, NC
	Jun 1978 – Jul 1979	Family Practice Intern, FT Bragg, NC

Rank	Colonel
Name	(b)(6)-2
Branch/MOS	Medical Service Corps / 72C
Current Duty Assignment	Garrison Commander, (b)(6)-2 (b)(6)-2

Brief History of Previous Assignments	Aug 03 – Present	Garrison Commander, (b)(6)-2 (b)(6)-2
	Jul 00 – Aug 03	Deputy Commander, U.S. Army Medical Research and Materiel Command, Fort Detrick, Frederick, MD 21702
	Aug 97 – Jul 00	Chief of Staff, U.S. Army Medical Research and Materiel Command, Fort Detrick, Frederick, MD 21702
	Jul 96 – Aug 97	Executive Officer, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, Washington, DC 20307
	May 93 – Jul 96	Secretary of the General Staff, U.S. Army Medical Research and Development Command, Fort Detrick, Frederick, MD 21702
	Jun 90 – Jun 92	Assistant Director, Army Audiology and Speech Center, Walter Reed Army Medical Center, Washington, DC 20307
	Jul 85 – Jun 90	Chief Audiology and Speech Pathology, Tripler Army Medical Center, Honolulu,HI
	Jun 82 – Jul 85	Chief Audiology Section, Fitzsimons Army Medical Center, Denver, Colorado
	Jan 81 – Dec 81	Audiology Consultant US Army Medical Command Korea, Yong San Korea
	Jan 78 – Dec 80	Audiologist, Madigan Army Medical Center, Tacoma, Washington

Rank	Colonel	
Name	(b)(6)-2	
Branch/MOS	Medical Corps / 61F9A	
Current Duty Assignment	Staff Internist and Intensivist, (b)(6)-2 Internal Medicine Consultant to the Army Surgeon General Governor, Army Chapter, American College of Physicians (b)(6)-2	
Brief History of Previous Assignments	2001-present	Staff Internist, (b)(6)-2
	2001-present	Army ACP Chapter Governor
	1997-present	OTSG Internal Medicine Consultant
	1996-1997	Director of Medical Education, Womack Army Medical Center
	1993-2001	Chief, Dept of Medicine, Womack Army MEDCEN
	1990-1993	Chief, Dept of Medicine, US Army Hospital, Heidelberg
	1986-1990	Chief, Internal Medicine Service, Dewitt Army Community Hospital, Ft Belvoir, VA
	1982-1986	Staff Internist, Frankfurt Army Regional MEDCEN
	1982	Advanced Course in Critical Care Medicine, LAMC
	1979-1982	Internship and Residency in Internal Medicine, BAMC

Rank	Colonel	
Name	(b)(6)-2	
Branch/MOS	Army Nurse Corps / 66H/66E	
Current Duty Assignment	Deputy Commander for Health Services, (b)(6)-2 (b)(6)-2	
Brief History of Previous Assignments	2002-2004	Chief, Medical-Surgical Nursing Section, Brooke Army Medical Center, San Antonio, TX
	1999-2002	Chief, Medical Support Branch, Joint Readiness Clinical Advisory Board, Fort Detrick, MD
	1997-1999	Chief Nurse, 10th Combat Support Hospital; deployed to Bosnia-Hergovina, Task Force Medical Eagle in support of Operation Joint Forge
	1995-1997	Chief, Perioperative Nursing Services, Fort Leonard Wood, MO
	1993-1995	Advisor to the Officer Advanced Course, AMEDD Center and School, Fort Sam Houston, TX
	1991-1992	Perioperative Nursing Educator and floor coordinator at Madigan Army Medical Center; assigned as FORSCOM nurse to the 47th Combat Support Hospital, Fort Lewis, WA
	1990-1991	Deployed as staff nurse and as an infection control officer with the 47th Combat Support Hospital; provided care to soldiers during Operation Desert Shield; unit reconfigured as a 24 bed hospital and followed the 24th Infantry Division into Iraq
	1989-1990	Head Nurse, Ambulatory Surgery Center, Madigan Army Medical Center; assigned as FORSCOM nurse to the 47th Combat Support Hospital, Fort Lewis, WA
	1985-1988	Operating Room Staff Nurse/Infection Control Officer, Berlin, MEDDAC Berlin, West Germany
	1982-1985	Operating Room Staff Nurse, Madigan Army Medical Center

Rank	LTC	
Name	(b)(6)-2	
Branch/MOS	JAG/27A	
Current Duty Assignment	Staff Judge Advocate (b)(6)-2	
Brief History of Previous Assignments	Jul 02 - Jun 03	Deputy Staff Judge Advocate, III Corps & Fort Hood, TX
	Jul 00 – Jun 02	Chief, Administrative & Civil Law III Corps & Fort Hood, TX
	Jul 98 – Jun 00	Executive Officer & Chief, Criminal Law U.S. Forces Korea & 8th Army
	Jul 96 – Jun 98	Instructor Air Force Judge Advocate School Maxwell AFB, AL
	Jun 95 – Jun 96	Chief, Criminal Law Fort Sill, OK
	Jul 94 – May 95	JAG Graduate Course Charlottesville, VA
	Jul 94 – Jun 95	Senior Defense Counsel Fort Sill, OK
	Apr 91 – Jun 93	Chief, Legal Assistance, Trial Counsel, & Administrative Law Attorney 101st & Fort Campbell, KY
	Sep 90 – Mar 91	Brigade Legal Advisor Desert Shield / Desert Storm
	Jan 88 – Aug 90	Chief, Claims, Legal Assistance Attorney Fort McClellan, AL

Rank	Major
Name	(b)(6)-2 USAR
Branch/MOS	Medical Corps / 61F
Current Duty Assignment	Program Director, Internal Medicine Residency Program, (b)(6)-2

Brief History of Previous Assignments	2003 Chief, Internal Medicine Service, Womack Army Medical Center 2002 -- 2003 Staff Internist, Womack Army Medical Center 2001 -- 2002 Clinical Assistant Professor of Medicine, University of Washington Medical School, Seattle, WA 1998 -- 2002 Staff Internist, Adult Primary Care Clinic, Department of Medicine, Madigan Army Medical Center 2000 -- 2002 Director, Intern Training and Assistant Program Director, Transitional Residency Program, Madigan Army Medical Center 1999 -- 2000 PROFIS Field Surgeon, 296 FSB, Fort Lewis, WA 1998 -- 1999 Chief, Medical Residents, Madigan Army Medical Center 1995 -- 1998 Intern and Resident in Internal Medicine, Madigan Army Medical Center

Rank	Master Sergeant
Name	(b)(6)-2
Branch/MOS	91W5H
Current Duty Assignment	Soldier Medic Training Site NCOIC, (b)(6)-2 (b)(6)-2

Brief History of Previous Assignments	Jan 04 – Present	Current Assignment
	Feb 03 – Dec 03	115th FH, Fort Polk, LA, Platoon Sergeant//EMT NCOIC (Deployed to OIF: March 03 – Jun 03 Camp Arifijan, Kuwait)
	Nov 01 – Jan 03	565th Ground Ambulance Co, Ft Polk, LA Platoon Sergeant
	Sep 01 – Oct 01	ANCOC, Ft Sam Houston, TX
	Nov 98 – Aug 01	USAREC: Cary, NC Recruiting Station and Barstow, CA Recruiting Station Detailed Recruiter
	Nov 96 – Oct 98	1/11th ACR, Ft Irwin, CA Medical Evacuation Section Sergeant
	Oct 95 – Oct 96	United Nations Command Security Battalion, Joint Security Area, Camp Bonifas, Korea Medical Evacuation Section Sergeant
	May 95 – Sept 95	BNCOC, Ft Sam Houston, TX
	Jul 94 – May 95	5th Engineer BN (C)(M) FLW, MO Medical Section Sergeant
	Jan 92 – Jun 94	93rd Evacuation Hospital, Ft. Leonard Wood, MO Medical Specialist in MCW
	Dec 90 – Dec 91	296th FSB, Camp Edwards, Korea Aidman in Treatment section
	Jun 90 – Nov 90	IET and AIT

Chapter 25 - Exhibit C, Annex 1
Interview Script

I have been appointed by The Surgeon General of the Army as a member of a medical assessment team. We have been tasked to look at medical operations in a deployed theater, pre-deployment training, in theater training, post-deployment training, and detainee medical care and documentation. This is an assessment/evaluation, not an investigation. We are seeking input to improve future training and medical capabilities, as well as evaluating medical personnel's understanding of their obligations under Army regulations and international law.

[If requested, show interviewee a copy of the **team** appointment letter]

Although this is not an investigation, we are required to document the information obtained from our one-on-one interviews as official, sworn statements.

I will be asking you to complete two documents. The first is a Privacy Act Statement. The second will be your official statement. The Privacy Act Statement explains the various uses for the information you provide me. Your statement will consist of answers to a standard set of questions and any additional information, not covered by the standard questions, that you provide me. We will also complete a questionnaire cover sheet. The cover sheet provides background information about your duty history and information about your unit. It is important that you provide me complete, honest answers to all questions. I again want to emphasize that this is an assessment, not an investigation.

Prior to beginning the interview I will ask you to respond to some scenario questions.

After completing the scenario questions ask -

Do you have any questions before we begin the interview?

INTERVIEW PROCEDURE

1. Complete Privacy Act Statement.
2. Complete background cover sheet.
3. Complete questionnaire, ensure each page is reviewed and initialed.
4. Ensure you have completed the information on the top of each page.
5. Read the Affidavit portion on the last page word for word to the interviewee.
6. Have the interviewee acknowledge that they understand the Affidavit.
7. Have the interviewee sign the statement.
8. Complete the date and location of the statement.
9. Sign and print your name.
10. Your authority to administer oaths is "**Acting Adjutant**."

DA Form 3881 (If needed)

On first line of Section A cross out "with the United States Army" and write in "a member of a medical assessment team."

LTC (b)(6)-2

Chapter 25 - Exhibit C, Annex 2
Questionnaire Cover Sheet

Record # (office entry)	

Date of Interview	DD-MMM-YR	**Location of Interview**	
Interviewer		**Rank of Interviewer**	MG COL LTC MAJ MSG

INTERVIEWEE	**First Name**		**MI**	**Last Name**			
Rank	**MOS/AOC**			**Gender**	Male Female	**Age**	
Years of Active Military Service		**Years of USAR/NG Service**			**Component**	AC RC NG	

PRESENT UNIT:					
Unit Name		**Address**			
City/Post		**State**	**Zip**		**Yrs Assigned**
Phone No.		**Unit Email**			
Unit Commander					

DEPLOYMENT HISTORY:					
Deployment Status	Past Present Future N/A	**Level**	1 2 3	**Theater**	GTMO OEF OIF
Name of Unit Deployed With:					
Specific Location of Unit in Theater					
Theater Date of Arrival	DD-MMM-YR	**Theater Date of Departure**	DD-MMM-YR		
Name of Medical OIC					

Reassigned in Theater?	Y N	**If YES, Name of Unit Attached to**	
Level	1 2 3	**Name of Medical OIC**	
Did you receive additional training at the new unit?	YES NO		
Explain:			

Did your unit provide detainee medical care in theatre?	YES NO
If YES, which unit? (use this unit for the assessment)	
Did you provide detainee medical care in theatre?	YES NO

MEDICAL DUTY:

1	MP Medic	9	CSH DCCS	17	ASMC PA
2	Maneuver Medic	10	CSH DCA	18	ASMC Doctor
3	ASMC Medic	11	CSH Chief Nurse	19	Medical Co CO
4	CSH 91W	12	CSH Senior Clinical NCO	20	DIV Surgeon
5	CSH 91WM6	13	Maneuver PA	21	BDE Surgeon
6	Nurse	14	Maneuver Doctor	22	BN Surgeon
7	CSH Doctor	15	MP PA	23	Dentist/Oral Surgeon
8	CSH Cdr	16	MP Doc	24	Administrative
26	Other:			25	Non-medical Leader

COMMENTS:

Chapter 25 - Exhibit C, Annex 3
Privacy Act Statement

SUBJECT: Privacy Act Statement

1. AUTHORITY: The authority for the collection of personal information during the conduct of this assessment is Title 10, United States Code, Section 3012 (10 USC 3012).

2. PRINCIPAL PURPOSE: The purpose for soliciting this information is to assist The Surgeon General in assessing Medical Training, Operations and Treatment in OEF and OIF.

3. ROUTINE USES: Any information you provide is disclosable to members of the Department of Defense (DoD) who have a need for the information in the performance of their duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

4. DISCLOSURE MANDATORY; THE EFFECT OF NOT PROVIDING INFORMATION:

a. For individuals warned of their rights under Article 31, UCMJ, or the Fifth Amendment to the U.S. Constitution:

"Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information which might not otherwise be available to the commander for his decision(s)in this matter."

b. For individuals who may be ordered to testify:

"Providing the information is mandatory. Failure to provide information could result in disciplinary or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations."

Date:_____ Name:_____ Signature: _____

Chapter 25 - Exhibit C, Annex 4
Past/Present Questionnaire

Printed on DA FORM 2823, DEC 1998 - SWORN STATEMENT

MEDICAL DUTY CATEGORIES TO ANSWER	TQ num	KQ let	QUESTIONS	RESPONSES
ALL	1	cef	Are you familiar with the Geneva Conventions?	Y N U NA
1-24 inclusive, 26	2	ef	In preparation for providing detainee care did your unit use case studies?	Y N U NA
ALL	3	ef	Did your overall unit training prepare you for addressing human rights issues of detainees?	Y N U NA
1-24 inclusive, 26	4	ef	Did your training prepare you for providing medical care to detainees?	Y N U NA
1-24 inclusive, 26	5	ef	How would you rate your training to prepare you for detainee care?	E G N F P
ALL	6	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? *Format?*	
ALL	7	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? *How Often?*	
ALL	8	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? *When?*	
26	150	d	What orders did you get from higher HQ regarding the provision of detainee medical care? (If written, please provide a copy of the orders.)	
26	151	d	What was your understanding of the policy regarding detainee medical care?	
26	152	d	Were you involved in the planning of detainee care?	Y N U NA
26	153	d	What was your planning sequence? (Please provide the plan and orders.)	

26	154	d	What was your understanding of the requirements of running a detainee medical facility?										
26	155	d	What was your understanding of the special concerns for this population, i.e., chain of custody for medical records, interrogators in the facility, etc?										
26	156	d	What resources did you request to accomplish this mission?										
26	157	d	Who did you ask for these resources?										
26	158	d	Were these resources provided to you?	Y	N	U	NA						
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	9	cef	Were you provided with instructions about the procedure to document medical screening of detainees?	Y	N	U	NA						
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	10	d	Is there a detainee daily sick call?	Y	N	U	NA						
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	11	dl	Was there/Is there an initial assessment at the detention facility of detainees to assess their physical condition?	Y	N	U	NA						
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	12	dk	How do you rate detainee facility sanitation?	E	G	N	F	P					
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	13	dk	How do you rate detainee temperature environment?	E	G	N	F	P					
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	14	dk	How do your rate detainee bedding?	E	G	N	F	P					
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	15	dk	How do you rate detainee clothing?	E	G	N	F	P					
1,2,3,13,14,15,16,17, 18,19,20,21,22	16	cdef	Are monthly medical screens performed?	Y	N	U	NA						
1,2,3,13,14,15,16,17, 18,19,20,21,22	17	cdef	Are monthly weights recorded?	Y	N	U	NA						

ALL	18	d	Were there detained women?	Y	N	U	NA		
ALL	19	d	Were there any policies for detained women?	Y	N	U	NA		
ALL	20	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	21	d	Were there detained children (16 years and younger) ?	Y	N	U	NA		
ALL	22	d	Were there any policies for detained children (16 years and younger)?	Y	N	U	NA		
ALL	23	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	24	d	Were there detainees with contagious illnesses?	Y	N	U	NA		
ALL	25	d	Were there any policies for detainees with contagious illnesses?	Y	N	U	NA		
ALL	26	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	27	d	Were there detainees with mental illnesses?	Y	N	U	NA		
ALL	28	d	Were there any policies for detainees with mental illnesses?	Y	N	U	NA		
ALL	29	d	Did your unit follow these policies?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24, 26	30	dl	Was informed consent obtained from detainees when indicated? (same standard as for other patients)	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22	31	d	Is there a policy for immunizing detainees?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22	32	d	Did your unit follow these policies?	Y	N	U	NA		
9,10,11,12,19,20,21,24,25	33	d	Is a detainee's medical condition made available to family members? (if entered into a system = yes)	Y	N	U	NA		
1-23, 25, 26	34	dk	Were detainees restrained in your facility?	Y	N	U	NA		
1-23, 25, 26	35	dk	Restrained for inability to comprehend or follow instructions?	Y	N	U	NA		
1-23, 25, 26	36	dk	Restrained for punishment?	Y	N	U	NA		
1-23, 25, 26	37	dk	Restrained for attempt to dislodge medical device?	Y	N	U	NA		
1-23, 25, 26	38	dk	Restrained for risk for falling?	Y	N	U	NA		
1-23, 25, 26	39	dk	Restrained for violent or disruptive behavior?	Y	N	U	NA		
1-23 inclusive, 26	40	dl	How would you rate the quality of documentation re: restraining detainees in your facility?	E	G	N	F	P	0

ALL	41	dk	How do you rate detainee medical resources?	E	G	N	F	P	0	
ALL	42	dk	How do you rate detainee medication resources?	E	G	N	F	P	0	
ALL	43	dk	How do your rate detainee medical supplies?	E	G	N	F	P	0	
ALL	44	dk	How do you rate detainee medical personnel resources?	E	G	N	F	P	0	
ALL	45	dk	How do you rate detainee medical evacuation resources?	E	G	N	F	P	0	
1,2,3,13,14,15,16,17,18,19,21,22,23,25	46	def	Are you familiar with the procedures to send detainees to higher levels of care?	Y	N	U	NA			
1,2,3,13,14,15,16,17,18,19,21,22,23,25	47	d	Did your unit follow these procedures?	Y	N	U	NA			
1,15,16,17,18,19,25	48	dh	Does your unit have BSCTs?	Y	N	U	NA			
1,15,16,17,18,19,25	49	dh	Did any member of the BSCT provide medical care to US Soldiers?	Y	N	U	NA			
1,15,16,17,18,19,25	50	dhi	Did any member of the BSCT provide medical care to detainees?	Y	N	U	NA			
ALL	51	c	Have you received MOS or other school training about reporting possible detainee abuse? (non-unit level/related)	Y	N	U	NA			
ALL	52	ef	Have you received unit training at your home station about reporting possible detainee abuse?	Y	N	U	NA			
ALL	53	ef	Have you received unit training during mobilization about reporting possible detainee abuse?	Y	N	U	NA			
ALL	54	ef	Have you received unit training in theater about reporting possible detainee abuse?	Y	N	U	NA			
ALL	55	n	Are there unit-level policies that require reporting suspected abuse?	Y	N	U	NA			
ALL	56	n	Did your unit follow these policies?	Y	N	U	NA			
1-23,25, 26	57	h	Were medical personnel ever asked to participate in interrogations?	Y	N	U	NA			
1-23,25, 26	58	h	In what way?							
4,5,6,7,8,9,10,11,12,23,24, 26	59	cdhi	Did/does your unit have a digital or other high quality camera for use in documentation of patient injuries?	Y	N	U	NA			
4,5,6,7,8,9,10,11,12,23,24, 26	60	cdhi	Did your unit photograph patient injuries?	Y	N	U	NA			
4,5,6,7,8,9,10,11,12,23,24, 26	61	cdhi	Did pictures include faces?	Y	N	U	NA			

1-19,21,22,23,26	62	dh	Was there a policy on interrogators in your medical facility?	Y	N	U	NA	
1-19,21,22,23,26	63	dh	Was there a policy on conducting interrogations in your medical facility?	Y	N	U	NA	
1-19,21,22,23,26	64	def h	Did you ever get instruction on that policy?	Y	N	U	NA	
1-18,21,22,23,26	65	hk	Were you ever asked to be present during interrogations?	Y	N	U	NA	
1-18,21,22,23,26	66	hk	Were you aware of any medical personnel being asked to be present during interrogations?	Y	N	U	NA	
1-18,21,22,23,26	67	hk	Were you aware of any medical personnel being present during interrogations?	Y	N	U	NA	
1-18,21,22,23,26	68	hk	Were you ever present during interrogations?	Y	N	U	NA	
1-24 inclusive, 26	69	c	Have you received MOS or other school training about detainee medical records? (non unit related)	Y	N	U	NA	
1-24 inclusive, 26	70	ef	Have you received unit training at your home station about detainee medical records?	Y	N	U	NA	
1-24 inclusive, 26	71	ef	Have you received unit training during mobilization about detainee medical records?	Y	N	U	NA	
1-24 inclusive, 26	72	ef	Have you received unit training in theater about detainee medical records?	Y	N	U	NA	
1-24 inclusive, 26	73	d	Are there theater policies regarding detainee medical records?	Y	N	U	NA	
1-24 inclusive, 26	74	d	Did your unit follow these policies?	Y	N	U	NA	
1,2,3,13,14,15,16,17, 18,19,21,22,24,25	75	hi	Were medical screenings completed in pre-interrogations?	Y	N	U	NA	
1,2,3,13,14,15,16,17, 18,19,21,22,24,25	76	hi	Were medical screenings completed in post-interrogation?	Y	N	U	NA	
1,2,3,13,14,15,16,17, 18,19,21,22,24,25	77	hi	Was there medical documentation in pre-interrogation?	Y	N	U	NA	
1,2,3,13,14,15,16,17, 18,19,21,22,24,25	78	hi	Was there medical documentation in post-interrogation?	Y	N	U	NA	
1,2,3,13,14,15,16,17, 18,19,21,22,24,25	79	hi	Was the medical documentation included in the detainee medical record?	Y	N	U	NA	
1-24 inclusive, 26	80	i	Where are original detainee medical records maintained? none maintained	Y	N	U	NA	
1-24 inclusive, 26	81	i	in detention facility	Y	N	U	NA	
1-24 inclusive, 26	82	i	in detention medical facility	Y	N	U	NA	
1-24 inclusive, 26	83	i	in interrogation record/facility	Y	N	U	NA	
1-24 inclusive, 26	84	i	sent to level 3 facility	Y	N	U	NA	
1-24 inclusive, 26	85	i	transferred with the detainee to next detainee facility	Y	N	U	NA	
1-24 inclusive, 26	86	i	in a log book only	Y	N	U	NA	
1-24 inclusive, 26	87	i	don't know	Y	N	U	NA	
1-24 inclusive, 26	88	i	Other:	Y	N	U	NA	

1-24 inclusive, 26	89	j	Were copies ever made of detainee medical records? If yes,	Y	N	U	NA			
1-24 inclusive, 26	90	j	Where are the copies of detainee medical records maintained? none maintained	Y	N	U	NA			
1-24 inclusive, 26	91	j	in detention facility	Y	N	U	NA			
1-24 inclusive, 26	92	j	in detention medical facility	Y	N	U	NA			
1-24 inclusive, 26	93	j	in interrogation record/facility	Y	N	U	NA			
1-24 inclusive, 26	94	j	sent to level 3 facility	Y	N	U	NA			
1-24 inclusive, 26	95	j	transferred with the detainee to next detainee facility	Y	N	U	NA			
1-24 inclusive, 26	96	j	in a log book only	Y	N	U	NA			
1-24 inclusive, 26	97	j	don't know	Y	N	U	NA			
1-24 inclusive, 26	98	j	Other:	Y	N	U	NA			
ALL	99	di	Were there procedures for controlling access to medical records of detainees?	Y	N	U	NA			
ALL	100	di	Were these procedures followed?	Y	N	U	NA			
ALL	101	di	Were there procedures for maintaining security of detainee records within your treatment area?	Y	N	U	NA			
ALL	102	di	Were these procedures followed?	Y	N	U	NA			
ALL	103	hi	Besides the treating medical personnel, who else was granted access to information in the detainee medical records? Anyone	Y	N	U	NA			
ALL	104	hi	BSCT	Y	N	U	NA			
ALL	105	hi	No one	Y	N	U	NA			
ALL	106	hi	Interrogators	Y	N	U	NA			
ALL	107	hi	My chain of command	Y	N	U	NA			
ALL	108	hi	Other:	Y	N	U	NA			
4-12, 23, 24, 26	109	j	What happened to the detainee records upon discharge from the hospital? Given to patient	Y	N	U	NA			
4-12, 23, 24, 26	110	j	Given to MP	Y	N	U	NA			
4-12, 23, 24, 26	111	j	Destroyed	Y	N	U	NA			
4-12, 23, 24, 26	112	j	I don't know	Y	N	U	NA			
4-12, 23, 24, 26	113	j	Transferred to the lower level medical facility	Y	N	U	NA			
4-12, 23, 24, 26	114	j	Maintained by the hospital	Y	N	U	NA			
4-12, 23, 24, 26	115	j	Forwarded to a repository	Y	N	U	NA			
ALL	116	k	How comfortable did you feel discussing ethical issues related to detainee care with your immediate supervisor?	VC	C	N	U	VU		

ALL	117	d	Are there policies, OPORDERS, or SOPs establishing criteria for detainee medical care and support?	Y	N	U	NA		
ALL	118	d	Are these policies briefed and discussed with unit personnel?	Y	N	U	NA		
ALL	119	d	Did you observe non-medical personnel providing medical care?	Y	N	U	NA		
ALL	120	klm	Are you aware of retribution against someone who reported abuse?	Y	N	U	NA		
ALL	121	k	Are you aware of any detainee reporting abuse to any other US Soldier?	Y	N	U	NA		
ALL	122	lm	Do you know if action was taken?	Y	N	U	NA		
ALL	123	m	What happened?						
1-18,21,22,23,26	124	hk	Were you ever asked to participate in interrogation by administering assistive medications? (e.g. paralytics, sympathomimetics, sedative/hypnotics, etc.)	Y	N	U	NA		
1-18,21,22,23,26	125	hk	Were you aware of any medical personnel being asked to participate in interrogations by administering assistive medications?	Y	N	U	NA		
1-18,21,22,23,26	126	hk	Were you aware of any medical personnel participating in interrogations by administering medications?	Y	N	U	NA		
1-18,21,22,23,26	127	hk	Did you ever participate in interrogation by administering assistive medications?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	128	hk	Were you ever asked to delay an initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	129	hk	Did you ever delay an initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	130	hk	Were you aware of any medical personnel being asked to delay initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	131	hk	Were you aware of any medical personnel delaying initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	132	hk	Were you ever asked to treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	133	hk	Do you know anyone ever asked treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	134	hk	Do you know anyone who treated a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22 ,23	135	hk	Did you ever treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		

1-24 inclusive,26	136	hi	Do you know if anyone was ever asked to change detainee medical documentation?	Y	N	U	NA		
1-24 inclusive,26	137	hi	Do you know if anyone was ever asked to inaccurately document medical information in a detainee record?	Y	N	U	NA		
1-24 inclusive,26	138	hi	Were you ever asked to change detainee medical documentation?	Y	N	U	NA		
1-24 inclusive,26	139	hi	Were you ever asked to inaccurately document medical information in a detainee record?	Y	N	U	NA		
1-24 inclusive,26	140	hi	Did you ever change detainee medical documentation?	Y	N	U	NA		
ALL	141	k	Did any detainees report abuse directly to you?	Y	N	U	NA		
ALL	142	m	Did you report this?	Y	N	U	NA		
ALL	143	im	How did you report?						
ALL	145	k	Did you directly observe possible detainee abuse?	Y	N	U	NA		
ALL	146	m	Did you report this?	Y	N	U	NA		
ALL	147	im	How did you report?						
ALL	144		Is there anything I should have asked but didn't?	Y	N	U	NA		

MEDICAL DUTY CATEGORIES

ALL All categories below
1 MP Medic
2 Maneuver Medic
3 ASMC Medic
4 CSH 91W
5 CSH 91WM6
6 Nurse
7 CSH Physician
8 CSH Cdr
9 CSH DCCS
10 CSH I 27 Other:
11 CSH Chief Nurse
12 CSH Senior Clinical NCO
13 Maneuver PA
14 Maneuver Physician
15 MP PA
16 MP Physician
17 ASMC PA
18 ASMC Physician
19 Medical Co CO
20 DIV Surgeon
21 BDE Surgeon
22 BN Surgeon
23 Dentist/Oral Surgeon
24 Administrative
25 Non-medical Leader
26 Other: MEDBDE & Hospital Cdr, BSCT, etc.

TQ and KQ

TQ Num Team Question Number - Numbers established by Assessment Team
KQ Let Kiley Question Letter - from Appointment Memo

KEY TO RESPONSES

Y YES
N NO
U Unknown
NA Not Applicable
E Excellent
G Good
N Neutral
F Fair
P Poor
0 None
VC Very Comfortable
C Comfortable
N Neutral
U Uncomfortable
VU Very Uncomforatble

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MEDICAL DUTY CATEGORIES TO ANSWER	TQ num	KQ let	QUESTIONS	RESPONSES
ALL	1	cef	Are you familiar with the Geneva Conventions?	Y N U NA
1-24 inclusive, 26	2	ef	In preparation for providing detainee care does your unit use case studies?	Y N U NA
ALL	3	ef	Does your overall unit training prepare you for addressing human rights issues of detainees?	Y N U NA
1-24 inclusive, 26	4	ef	Does your training prepare you for providing medical care to detainees?	Y N U NA
1-24 inclusive, 26	5	ef	How would you rate your training to prepare you for detainee care?	E G N F P
ALL	6	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? **Format?**	
ALL	7	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? **How Often?**	
ALL	8	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? **When?**	
26	150	d	What orders did you get from higher HQ regarding the provision of detainee medical care? (if written, please provide a copy of the orders)	
26	151	d	What was your understanding of the policy regarding detainee medical care?	
26	152	d	Were you involved in the planning of detainee care?	Y N U NA
26	153	d	What was your planning sequence? (please provide the plan and orders)	

26	154	d	What was your understanding of the requirements of running a detainee medical facility?							
26	155	d	What was your understanding of the special concerns for this population, i.e., chain of custody for medical records, interrogators in the facility, etc?							
26	156	d	What resources did you request to accomplish this mission?							
26	157	d	Who did you ask for these resources?							
26	158	d	Were these resources provided to you?	Y	N	U	NA			
1,2,3,13,14,15,16,17, 18,19,20,21,22, 23	9	eef	Were you provided with instructions about the procedure to document medical screening of detainees?	Y	N	U	NA			
ALL	19	d	Are there any policies for detained women?	Y	N	U	NA			
ALL	22	d	Are there any policies for detained children (16 years and younger)?	Y	N	U	NA			
ALL	25	d	Are there any policies for detainees with contagious illnesses?	Y	N	U	NA			
ALL	28	d	Are there any policies for detainees with mental illnesses?	Y	N	U	NA			

1,2,3,13,14,15,16,17,18,19,20,21,22	31	d	Is there a policy for immunizing detainees?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,23,25	46	def	Are you familiar with the procedures to send detainees to higher levels of care?	Y	N	U	NA		
1,15,16,17,18,19,25	48	dh	Does your unit have BSCTs?	Y	N	U	NA		
ALL	51	e	Have you received MOS or other school training about reporting possible detainee abuse? (non-unit level/related)	Y	N	U	NA		
ALL	52	ef	Have you received unit training at your home station about reporting possible detainee abuse?	Y	N	U	NA		
ALL	53	ef	Have you received unit training during mobilization about reporting possible detainee abuse?	Y	N	U	NA		
ALL	55	n	Are there unit-level policies that require reporting suspected abuse?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24,26	59	edhi	Did/does your unit have a digital or other high quality camera for use in documentation of patient injuries?	Y	N	U	NA		
1-19,21,22,23,26	62	dh	Is there a policy on interrogators in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	63	dh	Is there a policy on conducting interrogations in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	64	defh	Did you ever get instruction on that policy?	Y	N	U	NA		
1-24 inclusive, 26	69	e	Have you received MOS or other school training about detainee medical records? (non unit related)	Y	N	U	NA		
1-24 inclusive, 26	70	ef	Have you received unit training at your home station about detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	71	ef	Have you received unit training during mobilization about detainee medical records?	Y	N	U	NA		

1-24 inclusive, 26	80	i	Where are original detainee medical records maintained? none maintained	Y	N	U	NA			
1-24 inclusive, 26	81	j	in detention facility	Y	N	U	NA			
1-24 inclusive, 26	82	j	in detention medical facility	Y	N	U	NA			
1-24 inclusive, 26	83	j	in interrogation record/facility	Y	N	U	NA			
1-24 inclusive, 26	84	j	sent to level 3 facility	Y	N	U	NA			
1-24 inclusive, 26	85	j	transferred with the detainee to next detainee facility	Y	N	U	NA			
1-24 inclusive, 26	86	j	in a log book only	Y	N	U	NA			
1-24 inclusive, 26	87	j	don't know	Y	N	U	NA			
1-24 inclusive, 26	88	j	Other:	Y	N	U	NA			
ALL	99	di	Are there procedures for controlling access to medical records of detainees?	Y	N	U	NA			
ALL	101	di	Are there procedures for maintaining security of detainee records within your treatment area?	Y	N	U	NA			
4-12, 23, 24, 26	109	j	What happens to the detainee records upon discharge from the hospital? Given to patient	Y	N	U	NA			
4-12, 23, 24, 26	110	j	Given to MP	Y	N	U	NA			
4-12, 23, 24, 26	111	j	Destroyed	Y	N	U	NA			
4-12, 23, 24, 26	112	j	I don't know	Y	N	U	NA			
4-12, 23, 24, 26	113	j	Transferred to the lower level medical facility	Y	N	U	NA			
4-12, 23, 24, 26	114	j	Maintained by the hospital	Y	N	U	NA			
4-12, 23, 24, 26	115	j	Forwarded to a repository	Y	N	U	NA			
ALL	116	k	How comfortable do you feel discussing ethical issues related to detainee care with your immediate supervisor?	VC	C	N	U	VU		
ALL	117	d	Are there policies, OPORDERS, or SOPs establishing criteria for detainee medical care and support?	Y	N	U	NA			
ALL	118	d	Are these policies briefed and discussed with unit personnel?	Y	N	U	NA			
ALL	120	klm	Are you aware of retribution against someone who reported abuse?	Y	N	U	NA			

ALL	144		Is there anything I should have asked but didn't?	Y	N	U	NA		

MEDICAL DUTY CATEGORIES

ALL All categories below
1 MP Medic
2 Maneuver Medic
3 ASMC Medic
4 CSH 91W
5 CSH 91WM6
6 Nurse
7 CSH Physician
8 CSH Cdr
9 CSH DCCS
10 CSH 27 Other:
11 CSH Chief Nurse
12 CSH Senior Clinical NCO
13 Maneuver PA
14 Maneuver Physician
15 MP PA
16 MP Physician
17 ASMC PA
18 ASMC Physician
19 Medical Co CO
20 DIV Surgeon
21 BDE Surgeon
22 BN Surgeon
23 Dentist/Oral Surgeon
24 Administrative
25 Non-medical Leader
26 Other: MEDBDE & Hospital Cdr, BSCT, etc.

TQ and KQ

TQ Num Team Question Number - Numbers established by Assessment Team
KQ Let Kiley Question Letter - from Appointment Memo

KEY TO RESPONSES

Y YES
N NO
U Unknown
NA Not Applicable
E Excellent
G Good
N Neutral
F Fair
P Poor
0 None
VC Very Comfortable
C Comfortable
N Neutral
U Uncomfortable
VU Very Uncomforatble

Chapter 25 - Exhibit C, Annex 6
Power Projection Platform / CONUS Replacement Center Questionnaire

Date: _____
POC Name: _____
POC Duty Position: _____
POC Telephone #: _____
POC Email: _____
Platform Location: Benning, Bliss, Bragg, Campbell, Carson, Dix, Drum, Eustis, Hood, Lewis, McCoy, Polk, Riley, Sill, Stewart **(circle one)**

TQ Num	Question				
300	Were you at a **MOB Training Site** or a **CRC Training Site**? (circle one)				
301	What drives the training you provide to units at this Power Projection Platform?				NA
302	Have you ever compared the training produced here with training produced at other Power Projection Platforms?	Y	N	U	NA
303	*Do you provide training for detainee operations?*	Y	N	U	NA
304	If Yes to #303, how many hours?				NA
305	If Yes to #303, what is the nature of this training? (Please provide a copy of training materials.)				NA
306	Do you cover medical operations for the detainee population?	Y	N	U	NA
307	Do you provide medical ethics training?	Y	N	U	NA
308	If Yes to # 307, how many hours?				NA
309	If Yes to # 307, who conducts this training? (unit, rank, MOS)				NA

310	If Yes to # 307, is it UNIT-SPECIFIC or GENERIC? (circle one)				NA
311	If Yes to # 307, is it THEATER-SPECIFIC OR GENERIC? (circle one)				NA
312	Do you provide Law of War Training?	Y	N	U	NA
313	If Yes to # 312, how many hours?				NA
314	If Yes to # 312, who conducts this training? (unit, rank, MOS)				NA
315	If Yes to # 312, is it UNIT-SPECIFIC or GENERIC? (circle one)				NA
316	If Yes to # 312, is it THEATER-SPECIFIC OR GENERIC? (circle one)				NA
317	Do you provide Geneva Convention Training?	Y	N	U	NA
318	If Yes to # 317, how many hours?				NA
319	If Yes to # 317, who conducts this training? (unit, rank, MOS)				NA
320	If Yes to # 317, is it UNIT-SPECIFIC or GENERIC? (circle one)				NA
321	If Yes to # 317, is it THEATER-SPECIFIC OR GENERIC? (circle one)				NA
322	Do you use scenario training for any portion of the pre-deployement training?	Y	N	U	NA
323	If Yes, to # 322, for what areas of training is this used?				NA

BSCT QUESTIONNAIRE

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TQ num	KQ let	QUESTION	RESPONSE			
401	d	When assigned to duty on the BSCT (or equivalent duty) did you have Written or Verbal orders? (Circle one)				
402	d	If written orders were provided to you, who wrote them? (please supply a copy of the orders)				
403	d	What was your rating chain? (please supply a copy of the OER and OER support form for the time of this duty)				
404	d	What was your technical chain of command?				
405	d	What doctrine or policy outlines your deployment in a BSCT role?				
406	hi	Define your scope of duties while serving in a BSCT position?				
407	hij	Define your duty limitations while in a BST position?				
408	d	Did you provide clinical services to detainees, interrogators, assigned personnel or referred personnel while assigned in a BSCT role?	Y	N	U	NA
409	d	Were you credentialed by the medical facility?	Y	N	U	NA

			Y	N	U	NA
410	h	Did you participate in the interrogation of detainees?				
411		Did the detainees seek your services as a psychologist / psychiatrist / behavioral health specialist / medical provider in any role?				
412	h	How did you interact with the interrogators?				
413	ij	Did you have knowledge of the detainees medical conditions?				
414	ij	Did you have access to the detainee medical records?				
415	ij	Did you have access to any information in the medical records? (eg through discussion with other medical personnel)				
416	ij	If Yes, what types of medical information?				
417	hil	Did you document the medical condition of the detainess?				
418	ijl	Where did you store those records?				
419		Did you ever feel conflicted in your position?				
420		Describe the nature of the conflict?				

421		How did you resolve the conflict?				
422		Do you think medical personnel should serve in a BSCT role for interrogation activities?	Y	N	U	NA
423	cef	Are you familiar with the Geneva Conventions?	Y	N	U	NA
424	ef	Did your overall unit training prepare you for addressing human rights issues of detainees?	Y	N	U	NA
425	k	Were you aware of anyone else observing or involved with possible abuse?	Y	N	U	NA
426	m	Do you know if this possible abuse was reported?	Y	N	U	NA
427	k	Did you observe any possible abuse of detainees?	Y	N	U	NA
428	m	Did you report the possible abuse?	Y	N	U	NA
429	m	To whom did you report the possible abuse?				
430		Is there anything else I need to know?	Y	N	U	NA

STUDENT QUESTIONNAIRE

Date:_____ **Rank:** _____ **Years Active Military Service:** _____ **Years USAR/NG Service:** _____

Current course (circle one): OBC, OAC, PLDC, BNOC, ANOC, 91W, 91WM6, Other: _____

Duration of current course in weeks: _____ **In what week are you currently enrolled?** _____

TQ Num	Questions	Answers					
601	At this point in your current course, has the training included the Geneva Conventions?	Y	N	Unk	NA		
602	At this point in your current course, has the training included the Law of War?	Y	N	Unk	NA		
603	At this point in your current course, has the training included AR 190-8 (Enemy Prisoners of War, Retained Personnel, Civilian Internees, and other Detainees)	Y	N	Unk	NA		
The following questions apply to the training in questions 601, 602 and 603:							
604	How many hours did the training in involve (total)?	<1	1 to 2	2 to 3	3 to 4	>5	
605	Was the training scenario based?	Y	N	Unk	NA		
606	Was there group discussion involved in the training?	Y	N	Unk	NA		
607	Did the training include the specifics of detainee treatment and medical care?	Y	N	Unk	NA		
608	Did the training include requirements for medical records keeping for a detainee	Y	N	Unk	NA		
609	Did the training include the specifics of medical reporting of detainee abuse?	Y	N	Unk	NA		
610	To what extent did the training raise your comfort level in being able to provide medical care for a detainee in a combat theater of operations?	excellent	good	neutral	fair	poor	none
611	To what extent did the training raise your comfort level with accurately documenting medical records on a detainee?	excellent	good	neutral	fair	poor	none
612	To what extent did the training raise your comfort level with medical reporting of detainee abuse?	excellent	good	neutral	fair	poor	none
613	Did the training you received conflict with any previous ethical or Law of War training you received?	Y	N	Unk	NA		
614	If Yes to # 613, how did it conflict?						
615	What would you suggest to make the training better?						

JRTC QUESTIONNAIRE

Date: _____
POC Name: _____
POC Duty Position: _____
POC Telephone #: _____
POC Email: _____

TQ Num	Question				
501	Are the units provided scenarios pertaining to the medical needs of detainees?	Y	N	U	NA
	At what level do the medical scenarios address detainee care (circle all that apply)?				
502	Level 1 (e.g., MP units, medical companies)	Y	N	U	NA
503	Level 2 (e.g., medical support battalions, FSTs, CSC units)	Y	N	U	NA
504	Level 3 (e.g., combat support hospitals)	Y	N	U	NA
505	Do you evaluate medical ethics training as it relates to the care of detainees?	Y	N	U	NA
506	If Yes to #506 , at the theater policy level?	Y	N	U	NA
507	If Yes, to #506 , at the unit policy level?	Y	N	U	NA
508	If Yes, to #506 , at the unit compliance level?	Y	N	U	NA
509	Do you evaluate Law of War as it relates to medical care of detainees?	Y	N	U	NA
510	If Yes to #510, at the theater policy level?	Y	N	U	NA
511	If Yes, to #510, at the unit policy level?	Y	N	U	NA
512	If Yes, to #510 , at the unit compliance level?	Y	N	U	NA

513	Do you evaluate Geneva Convention Training?	Y	N	U	NA
514	If Yes to # 514, at the theater policy level?	Y	N	U	NA
515	If Yes, to # 514, at the unit policy level?	Y	N	U	NA
516	If Yes, to # 514 , at the unit compliance level?	Y	N	U	NA
517	Is the evaluation of medical training to detainees annotated in the AAR?	Y	N	U	NA
518	Is the evaluation of medical ethics training, as it relates to medical care, annotated in the AAR?	Y	N	U	NA
519	Is the evaluation of Geneva Conventions training, as it relates to medical care, annotated in the AAR?	Y	N	U	NA
520	Is there anything else you wish to tell me?				

Chapter 26 – Exhibit D
Summary of Recommendations

The purpose of this Exhibit is to list all of the recommendations offered in this report. Some recommendations may be similar to others; however, all recommendations are included here.

26-1. Question a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?

None

26-2. Question b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?

None

26-3. Question c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?

a. *Medical Records Training*

(1) AMEDDC&S should ensure standardization of training of detainee healthcare documentation and disposition of retired detainee records across the entire healthcare spectrum in all theaters, from the point of capture and collection point to the detention facilities.

(2) Establish a team under the direction of the AMEDDC&S comprised of clinicians and PAD expertise with exceptional knowledge of the generation, storage, maintenance and collection (disposition) of detainee medical records from the point of capture and collection point to the detention facilities. The tasks and training content should be developed by this team. The AMEDDC&S should facilitate this process.

(a) The above team should analyze courses' POIs and LPs to determine training gaps in the generation, storage and collection of detainee medical records.

(b) The training should include a crosswalk of Geneva Conventions, DoD and DA regulations and policies pertaining to the generation, storage and collection of detainee medical records. Training content should be regularly revised to reflect changes in the policies.

(c) The training structure should include all levels of care, from point of capture and collection point to the detention facilities. Training should incorporate AC/RC TDA and TOE medical units and medical assets in MP and maneuver units.

(3) Create and deploy an exportable training package specific to the generation, storage and collection of detainee medical records for medical personnel in AC/RC TDA and TOE medical units. Medical assets assigned to AC/RC MP and maneuver units should receive the training package.

(4) PAD officers and senior PAD specialists should serve as the subject matter experts and training resource for AC/RC level II and III units. The PA or senior 91W should serve as the training resource for non-medical units.

(5) Incorporate training that is focused on the generation, storage and collection of detainee medical records into the 70E and 91G courses.

(6) Expand PAD "Just-in-Time Deployment Training" course to include deploying RC 70E and 91G personnel.

(7) Develop sustainment and proficiency training for 70E and 91G personnel in AC/RC units. Training and proficiency data for 70E and 91G personnel should be competency-based and reported regularly as part of the unit's readiness report.

b. *Detainee Abuse Training*

(1) Tools should be introduced to assist students in recalling their training; for example, a reference pocket training aid. The tool should display a decision algorithm to assist them in distinguishing actual or suspected abuse from injuries as a result of lawful combat operations.

(2) AMEDDC&S, as the proponent for training of medical personnel in detainee healthcare care (to include medical reporting of detainee abuse) across the entire healthcare spectrum in theater, from the point of capture and collection point to a detention facility should:

(a) Establish a SME team to develop the tasks and framework to build a comprehensive AMEDD training program. The framework should include all training platforms (MUIC, RTS, NTC, JRTC, and PPP) and methods of instruction (lecture, case studies, scenario, and AAR). The framework must encompass all levels of care, from point of capture to a detention facility. The framework must serve as an additional resource for TOE medical units and TDA facilities as part of the readiness component.

(b) SME Team membership should include appropriate representation from the RC and should have exceptional knowledge of detainee care at the point of capture, collection point and detention facilities. Additionally, the team should be comprised of a judge advocate, a medical ethicist, and SMEs serving in the prison health care system. The tasks and training content should be standardized particularly in the professional development and MOS specific courses.

(c) MOS-specific schools and professional development courses should incorporate case studies and scenario-based training on current Army operations. Training Centers, such as NTC and JRTC, should be provided with the means to provide realistic level I to level III detainee medical care training.

(d) Consider using regularly scheduled video teleconferences with 91W, 91WM6 students and Soldiers that experienced detainee care from the point of capture, collection point or detention facility to enhance learning followed with a Q and A format.

(e) Revise the existing exportable training package to include all tasks associated with detainee care. Incorporate selected incidents and allegations to serve as case studies or scenario play. The AMEDDC&S should facilitate development of the training package and push the products out.

(3) MEDCOM should provide all medical senior leaders (AC/RC) detention care policies, regulations and references which could be accessed through the AKO site. MEDCOM should continually update AKO so that evolving guidance, tools and references are current. The following criteria and content (not all inclusive) should be considered:

(a) Theater accessible.

(b) Approved for continuing education credit.

(c) Approved detention care competency tools.

(d) DoD detention care guidance.

(e) DA guidance relating to detention care.

(f) "Health Professional's Guide to Medical and Psychological Evaluation of Torture by Physician for Human Rights" as an example (Cit. 38).

(4) DoD-I 1322.24, Medical Readiness Training, 12 July 2002, (Cit. 21) should include detention care competencies. Competencies should be developed by SMEs possessing exceptional knowledge of detainee care at the point of capture, collection point and detention facilities and the prison health care system.

26-4. Question d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?

a. Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency. Specific areas of guidance should include, but are not limited to:

(1) Initial and continual screening assessments

(2) Medical care equal to standards for U.S. Soldiers in the theater of operation

(3) Informed consent

(4) Protection of detainee medical information

(5) Documentation in and handling of medical records

(6) Recognition, documentation, and reporting of suspected abuses

(7) Planning factors for medical resources required for detainee care

b. All medical personnel must be trained on this guidance, with follow-up assessment of competency.

c. Policies concerning detainee medical operations should be declassified to the greatest extent possible to allow for the widest application of recommendation (a) above.

d. Classified policies should be archived on secure command web pages as they are updated or as new ones are added, since this will allow one to evaluate policy implementation timelines.

e. Units having theater-level responsibilities (for example (b)(2)-2, should propagate DA or DoD guidance, with particular emphasis on units delivering level I or II care in their AOR.

26-5. Question e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

a. Leaders at all levels should conduct meaningful training and verify by following up with an assessment via a competency test, regardless of the unit's deployment status.

This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units, AC/RC prior to deploying to a theater of operation. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deploying and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can tailor their training, both pre-deployment/pre-mobilization, as well as during deployment/mobilization, to this mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

26-6. Question f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

Same as 26-5 (Question e).

22-7. Question g. Identify OEF and OIF detention medical facilities.

None

26-8. Question h. With respect to the detention medical facilities identified in subparagraph 2g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.

a. Authorize medical personnel to halt any interrogation or interrogation technique if the detainee's health or welfare is endangered.

b. Require interrogations to stop immediately if a detainee requires any medical treatment during the interrogation.

c. Authorize medical personnel to perform pre- and/or post-interrogation medical evaluations at their discretion.

d. Require pre- and/or post- interrogation medical evaluations be performed upon the request of an interrogator.

e. Require all pre-, during, and post-interrogation medical care to be documented and included in the detainee medical records.

f. Describe the process for documenting medical care delivered during or due to an interrogation.

g. Describe the process to report and document in the medical record suspected abuse.

h. Require medical personnel to be trained on the above recommendations, with follow-up assessment of competency to measure the effectiveness of training.

26-9. Question i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?

a. *DA guidance (DoD level is preferable) should*:

(1) Require that detainee medical records at facilities that deliver level III and higher care be generated in the same manner as records of U.S. patients in theater.

(2) Address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care.

(3) Define appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

(4) Address the need for uniform documentation, to include accurate identification of all individuals entering information into all detainee medical records.

(5) Clearly outline the rules for access to detainee medical records and provision of medical information to non-health care providers. The guidance should only permit release of detainee medical information to interrogators when needed to ensure the health and welfare of the detainee.

(6) Training of medical personnel. All medical personnel should be trained on the above and evaluated for competency.

b. *DA guidance (DoD level is preferable) should*:

(1) Define who has access to detainee medical information and under what circumstances.

(2) Require that all military personnel are trained on this policy and evaluated for competency.

26-10. Question j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.

See 26-9 (Question i).

26-11. Question k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?

a. A DA definition of detainee abuse should be adopted (a DoD definition is preferable).

b. At all levels of professional training medical personnel should receive instruction on the definition of detainee abuse and the requirement to document and report actual or suspected detainee abuse.

c. Pocket cards be developed and distributed to all deploying medical personnel with "Medical Rules of Engagement" on the front and a training aid on detainee abuse on the back.

26-12. Question l. Did any medical personnel aware of, or who treated actual or suspected detainee abuse properly document the abuse?

a. A DA definition of detainee abuse be adopted (a DoD level definition is preferable).

b. A DA standard requiring actual, alleged or suspected abuse be documented in a detainee's medical record (a DoD level standard is preferable). The standard should require:

(1) Documentation of actual, alleged or suspected abuse in the detainee's medical record.

(2) The medical provider's opinion if the medical evidence supports actual, alleged or suspected abuse; and

(3) The action taken by medical personnel:

(a) If the medical evidence fails to support the alleged abuse this fact should be noted in the detainee's medical record.

(b) If the medical evidence is consistent with abuse, or is inconclusive, medical personnel must report the alleged or suspected abuse to the hospital/MTF commander

(MEDCOM SJA Information Paper-Health Care Professional Detainee Reporting Requirements-8 Sep 04) (Cit. 31).

(c) A notation in the detainee's medical record that a report was made, when, and to whom.

c. A DA standard detainee medical screening form should be developed and fielded (a DoD level standard is preferable).

26-13. Question m. To whom did any medical personnel aware of, or who treated, detainee abuse, report such abuse?

a. At all levels of professional training, medical personnel should receive instruction on the requirement to document and report actual or suspected detainee abuse. This training should include the definition and signs of actual or suspected detainee abuse.

b. Scenario-based training on detecting detainee abuse should be developed and fielded at all PPPs, MUICs, and reserve medical training sites. All deploying medical personnel should receive this training prior to arrival in theater.

c. All deploying medical personnel, prior to arrival in theater, should receive refresher training on the requirements and procedures to document and report actual or suspected detainee abuse.

d. All individual and collective training for medical personnel (such as NTC, JRTC, Warfighters, and FTXs) should include reinforcing training on recognizing and reporting actual or suspected detainee abuse.

e. Follow-on competency evaluations should be incorporated into all training guidance and plans.

26-14. Question n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?

a. Clearly written standardized policies for documenting and reporting actual or suspected detainee abuse should exist at all levels of command (DoD, Army, Combatant Command, theater, and individual subordinate units). These policies must then receive command emphasis on a continuing basis.

b. Medical planners at all levels should ensure clearly written standardized guidance is provided to medical personnel. This guidance should list possible indicators of abuse and contain concise instruction on how, and to whom medical personnel should document and report actual or suspected abuse.

c. Develop DA level guidance (DoD level is preferable) on the procedures for processing allegations of abuse not supported by medical evidence. This guidance should contain clear instructions on how medical personnel should properly document allegations of abuse that are not further reported based on lack of medical evidence.

26-15. Other Issues

a. *Overview of Site Visits to Afghanistan (OEF), Cuba (GTMO), and Iraq (OIF)*

(1) CFLCC guidance, regulations, and standards in relation to detainee healthcare, to OEF and OIF theaters, should be standard across the AOR, consistent with DoD guidance, and disseminated to the lowest levels.

(2) Prior to the onset of operations, combat or humanitarian, dedicated translators must be embedded within level III healthcare units, for use by medical assets only.

(3) OIF medical commanders should ensure medical assets are in place, and have a viable system to replenish them when necessary, at level I or II facilities that have significant detainee contact.

(4) To ensure that medical information is protected, translators assisting medical personnel with detainee care should not assist interrogators who question the same detainees.

b. *OIF Theater Preparation for Detainee Care*

(1) The AMEDD should establish an experienced SME team to:

(a) Comprehensively define the personnel, equipment and supply needs for detainee operations.

(b) Develop a method to ensure a flexible delivery system for these special resources to the appropriate levels of care and for the entire timeline of future military operations.

(2) Military planners need to assume that there is a high likelihood for detainee operations in all future conflicts and must allocate resources for detainee medical care in the planning process.

c. *Medical Screening and Sick Call at the DIFs and Prisons*

(1) DA guidance (DoD level is preferable) should require:

(a) Initial medical screening examinations upon inprocessing to a detention facility.

(b) Daily access to medical care for all detainees.

(2) All military personnel must be trained on the above policy and demonstrate competency.

d. *Restraints/Security*

(1) DA (DoD level is preferable) should standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraint. Medical personnel must be trained on this guidance, with follow-up competency evaluations.

(2) Use of restraints on any patient should be appropriately documented in the medical record.

(3) All facilities providing level II or III care should be appropriately supplemented with MPs dedicated to provide detainee security.

e. *Medical Personnel Interactions with Interrogators*

(1) DA guidance (DoD level is preferable) should:

(a) Prohibit all medical personnel from participating in interrogations.[1] This includes medical personnel with specialized language skills serving as translators.

(b) Empower medical personnel to halt interrogations when any examination or treatment is required.

(2) All military personnel should be trained on the above recommendations.

(3) Scenario training is highly recommended.

(4) Follow-on competency evaluations should be incorporated into all training guidance and plans.

e. *Medical Personnel Photographing Detainees*

(1) DA guidance (DoD level is preferable) should:

[1] For purposes of this recommendation the term "participating in interrogations" refers to the active participation by medical personnel during an interrogation. For example, asking questions would be active participation. Medical personnel who assist in developing the plan of interrogation are not deemed to be "participating in an interrogation." Likewise, actual presence in the interrogation room may not constitute "participating in an interrogation." For example, personal observation by medical personnel to ensure the health and welfare of the detainee is not deemed to be "participation in the interrogation."

(a) Authorize photographing detainee patients for the exclusive purpose of including these photos in medical records, and not require informed consent for photographs used in this manner (consistent with AR 40-66).

(b) Mandate that photographs of detainees taken by medical personnel for other reasons, including future personal education material, research, or unit logs, must first have informed consent from the detainee.

(2) Guidance for the above should be included in AR 190-8, which is currently under revision.

e. *The Use of Behavioral Science Consultation Teams (BSCT) in the Interrogation Process*

(1) DoD develop well-defined doctrine and policy for the use of BSCT.

(2) DA, (preferably DoD) policy should permit only BSCT personnel to participate in interrogation planning.

(3) Psychiatrists/physicians should not be used in a BSCT role.

(4) All psychologists and behavioral health technicians serving in BSCT positions should receive structured training on the roles and responsibilities while functioning in this capacity.

(5) MI personnel should clearly understand the defined roles, responsibilities and limitations of behavioral health personnel serving in a BSCT position.

(6) All psychologists utilized as BSCT members should be senior, experienced personnel.

g. *Stress on Medical Personnel Providing Detainee Medical Care*

(1) MEDCOM should establish an experienced SME Team comprised of a psychiatrist, a psychologist, clinical representation from all levels of care and include representation from a Chaplain. The team should:

(a) Comprehensively define the training requirements for medical personnel for inclusion into their pre-deployment preparation.

(b) Consider revising CSC doctrine to effectively deliver support to medical personnel in theater.

(c) Develop an effective system to regularly monitor post deployment stress.

(d) Refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

(2) AMEDDC&S should develop the training content defined by the above team. The above team should approve the content. The training (not all inclusive) should include ethical dilemmas medical personnel face and the emotional aspects in providing care to insurgents and detainees.

(3) MEDCOM should assure post deployment mental health assessment of medical personnel and provide follow-up care.

26-16. Non-AMEDD Training

a. *Joint Readiness Training Center (JRTC)* (recommendations offered by JRTC personnel, not the Team)

(1) Establish a SME team comprised of expertise from clinicians to develop the tasks and framework to formalize the training program. The framework should encompass all levels of care, from point of capture to care in the detention facility.

(2) The above team should assess the current training, specifically the scenarios to determine training deficiencies and determine the best practices in improving the quality of training as it relates to detainee medical care.

(3) Since AMEDD personnel must be prepared to provide care across the entire healthcare spectrum in theater, from the point of capture and collection point to the prison facilities, the training content should be developed by medical personnel with exceptional knowledge of detainee care. Additionally, the team should be comprised of representation from JAG, a medical ethicist, and subject matter experts serving in the prison health care system. The team members should develop the content and the JRTC medical OCs should facilitate.

(4) Team membership should include representation from the NG and USAR personnel that served in these facilities as well as the active component.

(5) The training should include a crosswalk of DoD and DA regulations and policies pertaining to detainee medical care. Training content should be revised regularly to reflect changes in the policies.

(6) Define competencies for OCs. Ensure OCs are from every component.

b. *National Training Center (NTC)* (recommendations offered by NTC personnel, not the Team)

(1) Add a detainee medical operations specific task to the EFMB task list.

(2) Add detainee medical operations into CLS training – the true first interface between the fighting force medical provider and the detainee.

(3) Commanders need to incorporate detainee medical operations into the METL.

c. *Power Projection Platforms (PPPs)*

(1) PPPs need to ensure medical personnel deploying are able to use their time at the training site to prepare for their upcoming mission. They should not be tasked with non-training missions (such as providing routine medical care) unless a quantifiable training effect can be assessed from such medical care.

(2) PPPs need to make their training "theater-specific" to ensure Soldiers processing through are adequately informed of any unique theater challenges or dangers.

(3) Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers. Emphasis needs to be placed on reporting suspected or actual abuse.

(4) Units should still bear the responsibility of training Soldiers on detainee medical records.

d. *CONUS Replacement Centers (CRC)*

(1) CRCs need to look at opportunities to expand current detainee operations training to include more comprehensive teachings on reporting suspected or actual detainee abuse.

(2) Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers and use a scenario based component to enhance learning modalities. It needs to emphasize reporting suspected or actual abuse

(3) Units should still bear the responsibility of training Soldiers on detainee medical records.

e. *Military Intelligence*

DA, or preferably DoD, should exercise oversight in the revision of current interrogation training doctrine to ensure compatibility with the Geneva Conventions, the Law of War, and all policies that apply to medical personnel.

Chapter 27 – Exhibit E
References Reviewed by the Medical Functional Assessment Team

Reference
ACLU DOCUMENTS
CID Responsive Documents to ACLU Request
CID ACLU DOC Index Spreadsheet CSD ACLU DOC Index Spreadsheet
MEDCOM Consolidated ACLU DOC Index Spreadsheet PASBA ACLU DOC Index Spreadsheet (OEF_OIF Internees) Proponency Office ACLU DOC Index Spreadsheet
POLICY & REGULATORY
AFI 41-210 Patient Administration
AR 40-3 Medical, Dental, and Veterinary Care – 12 Nov 02
AR 40-5 Preventive Medicine – 15 Oct 90
AR 40-66 Medical Record Administration and Health Care Documentation – 20 Jul 04
AR 40-400 Patient Administration – 12 Mar 01
AR 190-8 Enemy Prisoner of War, Retained Personnel, Civilian Internees, and other Detainees – 1 Oct 97
AR 190-47 The Army Corrections System – 5 Apr 04
AR 350-1 Army Training & Education – 9 Apr 03
CJCSI 3290.01A Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel – 15 Oct 00
CJCSI 5810.01B Implementation of the DoD Law of War Program – 25 Mar 02
DA PAM 27-1 Treaties Governing Land Warfare – 7 Dec 56
DA PAM 27-24 Selected International Agreements, Volume II – 1 Dec 76
DoD Directive 2310.1 DoD Enemy POW Detainee Program – 18 Aug 94
DoD Directive 5100.77 DoD Law of War Program – 9 Dec 98
DoD Instruction 1322.24 Medical Readiness Training – 12 Jul 02
DoD 6025.18-R DoD Health Information Privacy Regulation – Jan 03
FM 3-19.1 (FM 19-1) Military Police Operations – 22 Mar 01
FM 3-19.40 (FM 19-40) Military Police Internment Resettlement Operations – 1 Aug 01
FM 4-02 (FM 8-10) Force Health Protection in a Global Environment – 13 Feb 03
FM 4-02.4 (FM 8-10-4) Medical Platoon Leaders' Handbook – 24 Aug 01
FM 4-02.10 Theater Hospitalization – 29 Dec 00
FM 4-02.12 Health Service Support in Corps and Echelons Above Corps – 2 Feb 04
FM 4-02.17 Preventive Medicine Services – 28 Aug 00
FM 4-02.21 Division and Brigade Surgeon's Handbook – 15 Nov 00
Geneva Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – 10 Dec 84
Geneva Convention on the Condition of the Wounded and Sick in Armed Forces – 12 Aug 49
Geneva Convention Relative to the Protection of Civilian Persons in Time of War – 12 Aug 49
Geneva Convention Relative to the Treatment of Prisoners of War – 12 Aug 49

Protocol (Protocol 1), Additional to the Geneva Conventions of 12 August 49, and relating to the Protection of Victims of International Armed Conflicts - Adopted 8 Jun 77
Hague Convention, Convention Respecting the Laws and Customs of War on Land – 18 Oct 1907
JP 3 Doctrine for Joint Operations – 10 Sep 01
JP 3-63 Joint Doctrine for Detainee Operations - Final Coordination Draft – 23 Mar 05
JP 4-06 Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations – 28 Aug 96
NAVMED P-117 Manual of the Medical Department, 23 Nov 94 – Reprinted 96
18 U.S.C. § 2441. War Crimes Act of 1996 (As Amended)
PUBLIC DOMAIN
American Medical Association's Code of Medical Ethics - 2002/2003 version
Borden Institutes' Books Military Medical Ethics - Volumes I & 2 - 2003
Vice Adm. Church's Comprehensive Review of Department of Defense (DoD) Interrogation Operations (Complete Report and Executive Summary)
Department of the Army Inspector General's (DAIG) Detainee Operations Inspection Report - 21 Jul 04
DoD Book Emergency War Surgery, 3rd Ed, 2004
MG Fay and LTG Jones Article 15-6 Investigation of the Abu Ghraib Prison and 205th Military Intelligence Brigade – Feb 04
International Committee of the Red Cross (ICRC) Report on the Treatment by Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Conventions in Iraq during Arrest, Internment, and Interrogation - Feb 04
International Corrections and Prisons Association's (ICPA) Book Practical Guidelines For the Establishment of Correctional Services Within United Nations Peace Operations - 01
BG Jacoby's Review of Detainee Operations and Facilities in Afghanistan – 26 July 04
Judge Advocate General's School Operational Law Handbook - 02
Judge Advocate General's School Law of War Workshop Deskbook - 00
MG Ryder's Assessment of Detention and Corrections Operations in Iraq – 6 Nov 03
Mr. Schlesinger's DoD Detention Operations Final Report – Aug 04
MG Taguba's Administrative Investigation of Alleged Detainee Abuse by the 800th Military Police Brigade, 24 JAN -9 Mar 04.
MEDCOM [Patient Administration Systems & Biostatistics Activity's (PASBA)] Memorandum "Deployment Medical Documentation Guidance/Reporting Requirements" – 12 Mar 04
Physician's for Human Rights'2001 Publication of "Examining Asylum Seekers – A Health Professional's Guide to Medical and Psychological Evaluations of Torture" – Aug 01
Physician's for Human Rights' 2002 Publication of "Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms"
United Nations Publication of "Standard Minimum Rules for the Treatment of Prisoners' 13 May 77
United Nations Publication of "Principles of Medical Ethics Relevant to the Role of Healthcare Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" – 18 Dec 82

United Nations Publication of "Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment" – 9 Dec 88
United Nations High Commissioner for Human Rights' Publication of "The Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" - 9 Aug 99
White House Press Release "President Issues Military Order – Detention, Treatment, and Trial of Certain Non-Citizens in the War Against Terrorism" – 13 Nov 01
White House Presidential Order Number 499 "Humane Treatment of Al Qaeda and Taliban Detainees" – 7 Feb 02
World Medical Association's (WMA) "Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of Which They Are Aware" – Sep 03
MEDIA COVERAGE
American Forces Press Service (Gilmore) "Medical Personnel Didn't Commit Widespread Detainee Abuse, Say DoD" -11 Feb 05
Army Times (Funk) "No Proof Found That Medics Took Part In Abuse, Torture" – 10 Feb 05
Associated Press (Ross) "Professor Accuses Doctors in Iraq Abuse" – 20 Aug 04
Boston Globe (Savage) "Probe Leaves Out Ex-Commander At Guantanamo" - 25 Feb 0
Boston Globe (Bender) "Higher General To Probe Alleged Abuse" – 1 Mar 05
CBS (AP) "Docs Complicit In Prison Abuse?" – 20 Aug 04
CBS (News Online) "U.S. military prisoner abuse inquiries" – 23 Aug 04
Chicago Sun Times (Higgins) "US Methods Criticized in Report on Guantanamo" – 1 Dec 04
City Journal (MacDonald) "How to Interrogate Terrorists" – Winter 05
Hastings Center Report (Rubenstein, Gross, Verkerk) "Medical Ethics in War time" – Nov/Dec 04
Knight Ridder Newspapers (Allam) "Despite Improvements, Abu Ghraib Still Presents Challenges for New Commander" – 22 Jan 05
Lancet (Editorial) "How complicit are doctors in abuses of detainees?" - 21 Aug 04
Lancet (Miles) "Abu Ghraib: its legacy for military medicine" - 21 Aug 04
Lancet (Silove) Book Review: " Challenges in fighting torture: from September 11 to Abu Ghraib" – 5 Jun 04
Miami Herald (Dodds) "Sexual Tactics Debased Detainees, Translator Says" - 28 Jan 05
NEJM (Lifton) "Human Rights -Doctors and Torture" – 29 Jul 04
NEJM (Comments to Editor – including DoD response) RE: "Doctors and Torture" – 7 Oct 04
NEJM (Gawande) "Casualties of War - Military Care for the Wounded from Iraq and Afghanistan" – 9 Dec 04
NEJM (Peoples, Jezior, Shriver) "Caring for the Wounded in Iraq – A Photo Essay" – 9 Dec 04
NEJM (Bloche & Marks) "When Doctors Go to War" – 6 Jan 05
New York Times (Zernike) "Only a Few Spoke Up on Abuse as Many Soldiers Stayed Silent" – 22 May 04
New York Times (Lewis) "Red Cross Finds Detainee Abuse In Guantanamo" – 30 Nov 04

New York Times (Bloche & Marks) "Triage At Abu Ghraib" – 4 Feb 05
New York Times (Schmitt) "New Interrogation Rules Set For Detainees In Iraq" 10 Mar 05
OSD PAO Transcript of Church Briefing on Detention Operations and Interrogation Techniques – 10 Mar 05
Seattle P.I. (AP) "Red Cross Sees Problems at Guantanamo" - 30 Nov 04
Stars and Stripes (Coon) "Task Force Oasis brings medicine to Abu Ghraib" – 6 Jun 04
Time Magazine (Zagorin) "The Abu Ghraib Scandal You Don't Know" – 14 Feb 05
USA Today (Squitieri & Moniz) "U.S. Army re-examines deaths of Iraqi prisoners" – 28 Jun 04
Washington Post (Slevin) "Detainees Medical Files Shared: Guantanamo Interrogators Access Criticized" -10 Jun 04
Washington Post (Eggen & Smith) "FBI Agents Allege Abuse of Detainees at Guantanamo" - 21 Dec 04
Washington Post (Smith & Eggen) "Justice Expands 'Torture' Definition" - 31 Dec 04
Washington Post (Reuters Report) "CIA is Ordered to Release Detainee Abuse Files" – 3 Feb 05
Washington Post (Xenakis) Letter to Editor "From Medics, Unhealthy Silence"- 6 Feb 05
Washington Post (Kiley) Response to Xenakis "A Healthy Silence" 10 Feb 05
Washington Post (Leonnig & Priest) "Detainees Accuse Female Interrogators" – 10 Feb 05
Washington Post (Graham) "Prisoner Uprising In Iraq Exposes New Risk for U.S." - 21 Feb 05
Washington Post (Smith & White) "Soldier Who Reported Abuse Was Sent to Psychiatrist" – 5 Mar 05
Washington Post (White & Smith) "Low-Level Leaders and Confusion Blamed" – 10 Mar 05
Washington Post (White & Graham) "Senators Question Absence of Blame in Abuse Report" – 11 Mar 05
Washington Post (Web Post) "Conditions at Guantanamo Bay: Defense Dept. Documents Detail Red Cross Comments on Detainee Treatment and Actions Taken in Response" – 18 Jun 04
Washington Post "A Guantanamo Timeline" – 4 Jan 05
Weekly Standard (MacDonald) "Torturing The Evidence The truth about the doctors at Guantanamo" – 24 Jan 05
World Socialist Web Site (Randall) "Bush's 'Torture Inc.' at Guantanamo" – 2 Dec 04
TESTIMONY
HASC Hearing on Iraqi Prisoner Abuse – 7 May 04
SASC Hearing on Iraqi Prisoner Abuse –7 May 04
SASC Hearing on Iraqi Prisoner Abuse – Morning of 11 May 04
SASC Hearing on Iraqi Prisoner Abuse – Afternoon 11 May 04
SASC Hearing on Iraqi Prisoner Abuse –19 May 04
TEAM RELATED
Appointment as Team Leader, Functional Assessment Team – 12 Nov 2004
Appointment of Members to Functional Assessment Team – 30 Nov 2004
COL (b)(6)-2 Email Traffic "Mission and Objectives of the Behavioral Science Consultation

Team (BSCT)" With COL (b)(6)-2 - 21 Dec 04

COL (b)(6)-2 Email Traffic "Notes from Meeting with (b)(6)-2 – 3 Feb 05

COL (b)(6)-2 Email Traffic "Followup Phone Call" From COL (b)(6)-2 4 Apr 05

COL (b)(6)-2 Email Traffic "Requested Lesson Plans" from Mr. (b)(6)-2 (AMEDD C&S) – 16 Dec 04

COL (b)(6)-2 Email Traffic "Exportable Training Package" to Col (b)(6)-2 (AMEDD C&S, C, Dept of Training Support) – 24 Mar 05

MAJ (b)(6)-2 Email Traffic "More Questions about the Catheter" to (b)(6)-2 – 25 Mar 05

MCJA MFR (Assessment Team Guidance) – 12 Nov 04

MCJA Rules of Instruction for Functional Assessment Team - Undated

Medical Legal Reference Matrix – Developed by Team 7 Apr 05

Team Summary of 28th CSH Medical Record Review – 29 Dec 04

Team Summary of Autopsy Case Reviews -

NOT READILY AVAILABLE

(b)(2)-2 Detainee Handling and Detention Facility SOP - 12 Mar 04

(b)(2)-2 Detainee Packet Checklist (blank)

(b)(2)-2 Detention Facility Assessment Form (Blank)

(b)(2)-2 Post OIF Operational AAR (Undated)

(b)(2)-2 Intensive Care Unit (ICU) SOP "Care of Detainees/EPW/Non-Combatant Civilians – 30 May 03

(b)(2)-2 Memorandum " Operation Iraqi Freedom: Surgical Experience of the (b)(2)-2 20 Oct 04

(b)(2)-2 "OIF Lessons Learned" Briefing – 26 Feb 05

(b)(2)-2 Memorandum (EPW Holding Facility Monthly Inspections) - 21 Sep 04

(b)(2)-2 "Medical Rules of Eligibility" Briefing – 17Feb 05

(b)(2)-2 EPW Legal References

(b)(6)-2 JAO Information Paper (Nutritional requirements for Iraqi enemy prisoners of war) – 10 Feb 03

(b)(2)-2 JAO Information Paper (Authority to use public vehicles for transportation of EPWs) – 15 Feb 03

(b)(2)-2 JAO Information Paper (Care of dead EPWs and civilian internees) – 20 Feb 03

(b)(2)-2 JAO Information Paper (Use of Riot Control Agents against Enemy Prisoners of War) - 22 Feb 03

(b)(2)-2 JAO Information Paper (Use of Enemy Prisoners of War for Labor and Services) – 24 Feb 03

(b)(2)-2 Guidance (Use of Force for EPW Guards) (Undated)

(b)(2)-2 Enclosure 1 (Training Requirements for OIF) to FRAGO 559 (Consolidated Deployment Training Guidance) to (b)(2)-2 OPORD 03-02 (Phantom Victory)

(b)(2)-2 91WM6 Training Requirements (Undated)

(b)(2)-2 Tab G Clinical Training to (b)(2)-2 FY 05 Annual training Guidance (Undated)

(b)(2)-2 Baghdad Central Correctional Facility (BCCF) Memorandum "Standards of Conduct (Policy Letter 1)" – 3 Jun 04

(b)(2)-2 Baghdad Central Correctional Facility (BCCF) SOP 8 "SOP Scheduled Sick Call (Bison 1-4)" 3 Jun 04

(b)(2)-2 Baghdad Central Correctional Facility (BCCF) SOP 21 "SOP Scheduled Sick Call (Cougar 1-2)" 3 Jun 04

(b)(2)-2 Baghdad Central Correctional Facility (BCCF) SOP 32 "SOP Scheduled Sick Call (Cougar 3)" 3 Jun 04

(b)(2)-2 Baghdad Central Correctional Facility (BCCF) Memorandum "Policy/Procedures Exceptions in Observance of Ramadan" – 5 Oct 04

(b)(2)-2 Detention Cell SOP - 1 Oct 99

(b)(2)-2 Memorandum "Interrogation Tactics and Treatment of Detainees" (Undated)

(b)(2)-2 Attachment (Detainee Medical Screening Sheet) to (b)(2)-2 (b)(2)-2 Memorandum "Interrogation Tactics and Treatment of Detainees" (Undated)

(b)(2)-2 "Elective Surgical Case Protocol for (b)(2)-2 - 12 May 04

(b)(2)-2 Commander Memorandum "Lessons Learned: (b)(2)-2 Prison Hospital, ABG, Iraq, Feb-Jul 04" 9 Mar 05

(b)(2)-2 Commander Memorandum "Accomplishments of (b)(2)-2 Baghdad Central Detention Facility Hospital, ABG, Iraq, OIF 2" - 9 Mar 05

(b)(2)-2 Commander Memorandum " Requirements for level I Healthcare at an Army-Run Detention Facility, Formulated to Comply with AR 190-8 and the Recommendations of ICRC Visits" – 9 Mar 05

(b)(2)-2 Annex Q (Medical Services) to (b)(2)-2 (EPW/CI) TACSOP (Undated)

AMEDD IPT Detainee Medical Care/Information Process Charter – 17 Jun 04

AMEDD IPT Detainee Medical Care Final Report to Deputy Surgeon General of the Army – 21 Jul 04

AMEDD IPT Detainee Medical Care Dissenting email from Mr (b)(6)-2 - 14 Jul 04

AMEDD IPT Detainee Medical Care Dissenting email from COL (b)(6)-2 (b)(6)-2 20 Jul 04

AMEDD IPT Detainee Medical Care Draft OTSG/MEDCOM Policy Memo xx-xxx – "Medical care of detainees, prisoners of war, internees, and retained personnel" – XX Jul 04

AMEDD IPT Detainee Medical Care Briefing 22 Oct 04 Version 2

Baghdad Central Correctional Facility (b)(2)-2 Detainee Suicide Prevention Plan (Undated)

Baghdad Central Detention Facility Point Paper "Military Health Support to a Military Detention Facility" – 25 Jan 04

Baghdad Central Detention Facility Hospital ""Internee Health Care" – 27 Jan 04

Baghdad Central Detention Facility Hospital "Medical Processing Briefing" (Undated)

Baghdad Central Detention Facility Hospital Layout and Task organization (Undated)

Baghdad Central Detention Facility Hospital Memorandum "Restraints" - Feb 04

Baghdad Central Detention Facility Hospital Memorandum "Care of Detainees" - Feb 04
Baghdad Central Detention Facility Hospital Memorandum "Management and Evaluation of Suspected Sexual Assault Victims" - Mar 04
Baghdad Central Detention Facility Hospital Memorandum "Suspected / Alleged Assault or Abuse" - Apr 04/Rev/Jun 04
Baghdad Central Detention Facility Hospital Memorandum " Family Visitation & Detainee Mail" - 13 Jun 04
Baghdad Central Detention Facility Hospital Memorandum "Patient Death" (Ver 1 - Apr 04)
Baghdad Central Detention Facility Hospital Memorandum "Patient Death" (Ver 2 Rev/Jun 04)
Camp Bucca, Iraq SOP (b)(2)-2 (EPW/CI)) - 1 Jun 04
Camp Bucca Internment Facility Dental Clinic SOP (b)(2)-2 - Mar 05
Central Air Force Command's "Concept of Operations for Detainee Health Team in Support of Military Intelligence Interrogation Operations" – 23 Jan 04
CFLCC Medical Rules Of Care - 12 Jan 03
(b)(2)-2 Policy Memorandum #12 – Medical Rules of Eligibility" Detainee Operations (Undated)
(b)(2)-2 CG Policy Memorandum 18 – Proper Conduct During Combat Operations – 4 Mar 04
(b)(2)-2 JA Information Paper - Scope of Medical Care Required for Security Detainees - 2 May 04
(b)(2)-2 JA Information Paper - Minimum Standards of Treatment Applied to Security Internees - 7 May 04
(b)(2)-2 Prisoner Health Patient Records
(b)(2)-2 Bagram Holding Area (BHA) and Kandahar Holding Area (KHA) Detainee Medical Standing Operating Procedure (SOP) MFR - 14 Aug 04
(b)(2)-2 Bagram Holding Area SOP - 29 Sep 04
Annex W-1 (Medical) to (b)(2)-2 Bagram Holding Area SOP
Annex W-2 (Medical) – Guarding and Transferring PUCs Under the Care of The BHA Physician to (b)(2)-2 Bagram Holding Area SOP
CSA Correspondence - Army Detainee Operations & Detainee-Interrogation Operations Integration - 17 Sep 04
CSA Correspondence – Appendices to Annex B Army Detainee Operations & Detainee-Interrogation Operations Integration Plan(Synch Matrix) v2.0 7 Oct 04
DoD Policy Memorandum on Medical Care for Enemy Persons Under U.S. Control Detained in Conjunction with Operation Enduring Freedom - 10 Apr 02
DoD Policy Memorandum on Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the United States - 9 Jun 04
DOJ (FOUO) Memorandum on the Legal Standards Applicable under 18 United States Code, Statutes 2340-2340A (Standards of Conduct for Interrogation) – 30 Dec 04
GTMO - Behavioral Science Consultation Team Joint Intelligence Group, (b)(2)-2 (b)(2)-2 SOP - 28 Mar 05 – Redacted Document
GTMO Memorandum "Operational Policy Memorandum 14 "Behavioral Science Consultation Team" – 10 Dec 04

GTMO Detainee Hospital SOP 010 - Medication Dispensing Policy - 18 Jan 04
GTMO Detainee Hospital SOP 011 Out-Processing Procedures - 21 Mar 03
GTMO Detainee Hospital SOP 014 Detainee Weight Management and Nutrition Program - 21 Mar 03
GTMO Detainee Hospital SOP 015 Mental Health Services to Detainees - 1 Feb 04
GTMO Detainee Hospital SOP 017 Detainee Medical Transports - 9 Mar 04
GTMO Detainee Hospital SOP 021 Infection Control (Undated)
GTMO Detainee Hospital SOP 029 Nursing - 3 Oct 03
GTMO Detainee Hospital SOP 034 Medical department Training (Undated)
GTMO Detainee Hospital SOP 035 Guidelines for Role of Independent Duty Corpsmen - 4 Mar 03
GTMO Detainee Hospital SOP 036 Guidelines for Role of Physician Assistants - 4 Mar 03
GTMO Detainee Hospital SOP 050 Detainee refusal of Care - 7 Aug 03
GTMO Detainee Hospital SOP 060 Cardiac Arrest Procedures at Camp Delta - Apr 04
GTMO Detainee Hospital SOP 061 Block Nurse (Undated)
GTMO Detainee Hospital SOP 068 Emergency Medical Treatment SOP - May 04
Joint Interrogation & Debriefing Center (JDIC) Briefing " Abu Ghrayb, Iraq" (Undated)
OSD-DA (FOUO) Detainee Medical Policy Briefing - Nov 04
OSD (FOUO) Memorandum Addressing the DOJ Memorandum on the US Statute Implementing the Convention Against Torture - 27 Jan 05
SECDEF DEPUTY Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees Under DoD Control - 12 Jan 05
SECDEF Policy Memorandum on Handling of Reports from the International Committee of the Red Cross - 14 Jul 04
MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 04
MNC-I Completed Technical Assist Visit Inspection of CP BIAP (Undated)
MNC-I Completed Technical Assist Visit Inspection of CP Victory - 10 Sep 04
MNC-I Completed Technical Assist Visit Inspection of CP Grey Wolf - 12 Sep 04
MNC-I Completed Technical Assist Visit Inspection of CP Curevo - 17 Sep 04
MNC-I Completed Technical Assist Visit Inspection of CP Renegade - 6 Oct 04
MNC-I Completed Technical Assist Visit Inspection of CP Caldwell - 7 Oct 04
MNC-IJA Information Paper "Scope of Medical Care for Security Detainees"- 29 Sep 04
MNF-I Surgeon's Information Brief (Mar-Apr 05
MNF-I (FOUO) Policy XX-YY (Detention Operations) – - 24 Jan 05
MNF-I Policy (Provision of Healthcare to Detainees) - 17 Feb 05
MNF-I SOP (Detainee Healthcare) - 21 Feb 05
MNF-I SOP (Tuberculosis Policy and Procedures) - 25 Feb 05
MNF-I SOP for Ensuring Separation of Detention Operations Functions (Healthcare, Interrogation Operations, and Custody and Control) - 12 Feb 05
MNF-I & MNC-I (FOUO) Detention Center Technical Assistance Visit Checklist (blank)
MNF-I Surgeon's 30 Day Assessment (Medical) for Feb 05 - 23 Feb 05
(b)(2)-2 Policy (Care of Iraqi Civilians at (b)(2)-2 FOB Abu Ghraib) - 25 Oct 04
(b)(2)-2 Mental Health Evaluations Policy – 1 Sep 04

(b)(2)-2 Mental Health Appraisal Policy – 1 Sep 04

(b)(2)-2 Mental Health Screening Policy – 15 Jan 05

(b)(2)-2 Detainee Mental Health Screening Checklist (English & Arabic)

(b)(2)-2 OIF Theater Detention Healthcare Policy - plus appendices - Jan 05

Appendix 1(Theater Policy Regarding the Physical Examination of Detainees) to OIF Theater Detention Healthcare Policy

Appendix 2 (Patient Right's, Rules, and Responsibilities – English and Arabic) to OIF Theater Detainee Healthcare Policy

Appendix 3 - (b)(2)-2 Detainee Operations "Standard Operating Procedures for Ensuring Separation of Detention Operation Functions (Healthcare, Interrogation Operations, and Custody and Control)" - 12 Feb 05

Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy

Enclosure - DETAINEE HEALTH AND MEDICAL RECORD OF quality assurance screen (SF600 overprint , ver 1.1, IAW AR 190-8) to Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy

Enclosure - DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION
(SF600 overprint, ver 1.4, IAW AR 190-8 to Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy

Appendix [Number not indicated] (Theater Policy Regarding the Dental In-Processing of Detainees) to the OIF Theater Detainee Healthcare Policy

Appendix 5 (Theater Detention Facility TB SOP) to OIF Theater Detention Healthcare Policy

Appendix 6 (Theater Policy for Detainee Patient Identification) to OIF Theater Detention Healthcare Policy

Appendix 7 (Theater Detainee Dispensary Services) to the OIF Theater Detention Healthcare Policy

Appendix 8 (Detainee Medication Administration Procedures) to OIF Theater Detainee Healthcare Policy

Appendix 11 (b)(2)-2 Standing Operating Procedure - Early Release of Detainee Due to Medical Circumstances – aka Compassionate Release SOP) to OIF Theater Detainee Healthcare Policy – 7 Nov 04

Appendix [Number not indicated] (Detainee Assault or Abuse Reporting) to OIF Theater Detention Healthcare Policy)

Appendix [Number not indicated] (Detainee Death Standard Operating Procedure) to the OIF Theater Detention Healthcare Policy

Appendix [Number not indicated] (Detainee Outpatient Wound Care) to OIF Theater Detention Healthcare Policy

(b)(2)-2 Mission Essential Task List (Undated)

(b)(2)-2 Poster "Tenets of Detention Healthcare" – Mar 05

(b)(2)-2 Soldier Cards "Tenets of Detention Healthcare" – Mar 05

(b)(2)-2 Detainee Operations Standard Operating Procedures for Detainee Healthcare and Medical Support to Interrogation Operations - 27 Sep 04

USSOUTHCOM Regulation 1-20 (Human Rights Policy and Procedures) - 8 Apr 02

USSOUTHCOM Confidentiality Policy for Interactions Between Health Care Providers

and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation Enduring Freedom - 6 Aug 02
USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba - 9 Aug 04
USSOUTHCOM (b)(2)-2 SJA Memorandum on "Initial Observations from ICRC Concerning Treatment of Detainees" – 21 Jan 02
USSOUTHCOM (b)(2)-2 SJA Memorandum on "Concerns Voiced by the International Committee for the Red Cross (ICRC) on Behalf of Detainees" – 24 Jan 02
USSOUTHCOM (b)(2)-2 SJA Minutes of ICRC Meeting – 2 Feb 04
USSOUTHCOM (b)(2)-2 SJA Memorandum for Record of ICRC Meeting Minutes – 9 Oct 03
TRAINING RELATED
(b)(2)-2 "Process Enemy Prisoners of War/Civilian Internees (EPWs/CIs) at a Collection Point or Holding Area" Briefing (Undated)
(b)(2)-2 , Office of Staff Judge Advocate "Law of War" Briefing (Undated)
HQ V United States Army FRAGO 7, Annex T (Revised Training Guidance for Forces Deploying ISO of Operation Iraqi Freedom after September 20, 2004) – 30 Sep 04.
HQ V United States Army Appendix 1 to Annex T (Revised Training Guidance for Forces Deploying ISO of Operation Iraqi Freedom after September 20, 2004) – 30 Sep 04.
HQ V United States Army Matrix (Individual and Collective training IAW OIF Change 3 MSG) (Undated)
(b)(2)-2 "Deployment Stress Management" Briefing (Undated)
Air Force Judge Advocate General School's Training Session on "The Law of Armed Conflict" (Undated)
Army Medical Department "Medical Ethics Training" Briefing (Undated)
AMEDD Center & School, Military Law Branch "Medical Care of EPW's, Detainees, and Civilian Internees" Briefing – 4 Aug 04
AMEDD Center & School, Patient Administration Branch "Medical Documents in Combat & Contingency Operations" Briefing – 14 Oct 04
AMEDD Center & School Review of Institutional Training In Accordance With AR 190-8 (Undated Excel Spreadsheet)
AMEDD Center & School (Dept of Healthcare Operations) Program of Instruction for 513-91G10 Patient Administration Specialist – 24 Apr 02
AMEDD Center & School (Dept of Combat Medic Training) Program of Instruction for 300-91W10 Healthcare Specialist – 16 Jul 03
AMEDD Center & School (Dept of Preventive Health Services) Program of Instruction for 302-91X10 Mental Health Specialist – 19 May 04
AMEDD Center & School (Dept of Health Services Administration) Program of Instruction for 513-91G10 Patient Administration Specialist – 30 Nov 04
AMEDD Center & School (Dept of Combat Medic Training) 91W PROPONENCY Pre-mobilizing Medical Refresher Training Matrix for USAR and NG units – 8 Dec 04
Consultant to the Surgeon General for Medical Ethics' "Medical Ethics in the Combat Zone" Briefing – 17 Nov 04
Lesson Plan - AMEDD BNCOC - Applied Ethics[WVBN039B / Version 1] 23 Jan 03

Lesson Plan - AMEDD BNCOC/Dental BNCOC - Dental Personnel in Alternate Wartime Roles [DPBN32Q0 / Version 1] - 05 Jan 04
Lesson Plan - AMEDD BNCOC - Manage Casualties (RTD, EVAC, DOW, POW) [WVBN014B / Version 5] - 08 May 02
Lesson Plan - AMEDD Captains Career & Warrant Officer Advanced (WOAC) - Laws of War and Operations Other Than War [FE1A1001 / Version 1] - 16 Sep 04
Lesson Plan - AMEDD Center & School - Effects of Geneva Conventions on Medical Evacuation [C191W034 / Version 1] - 27 Sep 00
Lesson Plan - AMEDD Center & School - Enemy Prisoner of War Procedures [JRC40570 / Version 1] - 01 Jun 04
Lesson Plan - AMEDD Center & School - FIELD TRAINING EXERCISE (EQB) [PEOS003A / Version 1.1] - 10 Sep 03
Lesson Plan - AMEDD Center & School - Geneva Convention on the Wounded and Sick [JRC4A220 / Version 1] - 01 Jun 04
Lesson Plan - AMEDD Center & School - Healthcare Jurisprudence [HLPADTOR / Version 1] - 09 Apr 01
Lesson Plan - AMEDD Center & School - Internally Displaced Persons (IDP) / Refugee Camp Assessments [PES00030 / Version 1] - 16 Dec 02
Lesson Plan [DRAFT] - AMEDD Center & School (91W10)- International Humanitarian Law and the Geneva Conventions – [30 Mar 05]
Lesson Plan - AMEDD Center & School - Law of War [WVBN042B / Version 1] - 04 May 01
Lesson Plan - AMEDD Center & School - Law of War [WVBN042B / Version 3] - 09 Nov 04
Lesson Plan - AMEDD Center & School - Law of War [HLOBCLOW / Version 04] - 03 Sep 04
Lesson Plan - AMEDD Center & School - Legal Aspects of Preventive Medicine [HLPREVMA / Version 03F] - 21 Mar 03
Lesson Plan - AMEDD Center & School (Medical Evacuation Doctrine & Flight Medics) - Geneva Convention [UE2C1302 / Version 1] - 18 Aug 03
Lesson Plan - AMEDD Center & School - Medical Legal Issues in Military Healthcare [HLOBCMED / Version 1.1] - 20 Sep 04
Lesson Plan - AMEDD Center & School - Military Justice [HLOBMJ00 / Version 0698] - 15 Sep 04
Lesson Plan - AMEDD NCO Advanced (NCOES) - Enemy Prisoner of War (EPW) Casualties [WYAN006B / Version 1] - 17 Apr 03
Lesson Plan - AMEDD NCO Advanced (NCOES) Law of War [WYAN039B / Version 1]15 Dec 04
Medical Paper (Murray, Roop, & Hospenthal) “Medical Problems of Detainees after the Conclusion of Major Ground Combat During Operation Iraqi Freedom” (Undated)
Power Projection Platform (Ft Bliss) Required Training List for All Individuals Processing Through the CONUS Replacement Center (CRC)” – 29 Nov 04
Power Projection Platform (Ft Bragg) Standard Training Package – “Coordinate Internee Hospitalization (191-384-4409) (Undated)
Power Projection Platform (Ft Bragg) Standard Training Package – “Issue Medication to Internees” (191-381-1338) – Oct 03

Power Projection Platform (Ft Bragg) Standard Training Package – "Supervise Administrative and Disciplinary Measures in an Internment Facility" (191-383-3396) – Oct 03
Power Projection Platform (Ft Bragg) Standard Training Package – "Supervise Work Activities Within an Internment Facility" (191-382-2352) - Oct 03
Power Projection Platform (Ft Bragg) Training Task – "Conduct Security Operations for Hospitalized Internees" (19-2-3510) – Jan 05
Power Projection Platform (Ft Bragg) Training Task – "Supervise Work Project Operations for Enemy Prisoners of War (EPWs) and Civilian Internees (CIs)" (19-2-3610) – Jan 05
Power Projection Platform (Ft Bragg) Training Task – "Supervise Work Project Operations for United States (US) Military Internees (19-2-3204) – Jan 05
Power Projection Platform (Ft Carson) – "7th Infantry Division & Ft Carson Detainee Training Guidance , 2nd Quarter, Fiscal Year (FY) 05" (Undated)
Power Projection Platform (Ft Hood) "Mandatory Briefings and Force Protection Lane Training" – 12 Jan 05
Power Projection Platform (Ft Lewis) "GTMO 6.0 Detainee Operations Brief" (Undated)
Power Projection Platform (Ft Riley) "Theater Specific Requirements for Operation Iraqi Freedom 05-07 – Version 1 CS/CSS (With FORSCOM 4 Guidance)" – 22 Feb 04
Power Projection Platform (Ft Stewart) "Medical Training Matrix for Mobilizing RC Combat Units" – 9 Jan 05 Training Support Package (TSP) to AR 190-8 for Medical Personnel who Handle, Treat, Monitor and or Evacuate Enemy Prisoners of War (EPW), Retained Personnel (RP), Civilian Internees (CI) and Other Detainees (Undated)
CLASSIFIED (S) Treatment of Enemy Combatants Detained at Naval Station Guantanamo Bay, Cuba, and Naval Consolidated Brig Charleston (dated 11 May 04)
(S) ANNEX Q to USARCENT OPLAN 1003-96 (Dated 1 April 1997) (S) APPENDIX 7 (MEDICAL) to ANNEX I to V CORPS OPLAN 1003 (Dated 1 December 1998)
(S) MNF-I ANNEX Q to MNF-I Framework OIPORD (U) - 22 Mar 05 (S) MNF-I ANNEX Q (Health Service Support) - 7 Dec 04
(S) MNF-I SOP (Intra-Theater Military Airlift for Security Detainees – DRAFT) - 1 Mar 05 (S) MNF-I Policy 05-02 (Interrogation Policy) - 27 Jan 05)
MNF-I Surgeon's 30 Day Assessment (Medical) for Jan 05 (Secret) - 25 Jan 05 MNF-I Surgeon's 30 Day Assessment (Medical) for Mar 05 (Secret) - 23 Mar 05
(S) MNC-I ANNEX Q (Health Service Support) TO MNC-I Campaign Plan: Operation Iraqi Freedom - 22 Aug 04 (S) MNC-I ANNEX Q TO MNC-I FRAMEWORK OPLAN (Medical Services) - 20 Mar 05 (Draft)
(S) FORSCOM FRAGO 20 to FORSCOM Deployment Order ISO Operation Iraqi Freedom Rotation 2 ([(b)(2)-2] DEPORD - Recognizes detainee HC shortfall) - 29 May 04
(S) Detainee Operations Responsibilities – 21 Jan 05
(S) V CORPS FRAGO 006M [Detention of Civilians] to V CORPS OPORD 0303-343 - 19 Mar 03

(S) V CORPS FRAGO 010M [V CORPS EPW Operations] to V CORPS OPORD 0303-343 - 19 Mar 03

(S) V CORPS FRAGO 018M [Obligations to Children Under Age 18 in U.S. Custody] to V CORPS OPORD 0303-343 - 24 Mar 03

(S) V CORPS FRAGO 037M [Change to FRAGO 010M: V CORPS EPW Operations] to V CORPS OPORD 0303-343 - 20 Mar 03

(S) V CORPS FRAGO 038M [Establishment of Class VIII Accounts] to V CORPS OPORD 0303-343 - 21 Mar 03

(S) V CORPS FRAGO 329M [Transition to Stability Operations in Baghdad Secured Zones] to V CORPS OPORD 0303-343 - 11 Apr 03

(S) V CORPS FRAGO 349M [Seizure of Iraqi Prisons] to V CORPS OPORD 0303-343 - 13 Apr 03

(S) (b)(2)-2 FRAGO 244 [Medical Supply Support Activity (SSA) Ordering and Inventory Management Requirements] to (b)(2)-2 OPORD 03-036 - 1 Jul 03)

(S) (b)(2)-2 FRAGO 344 [Armed Security for Enemy Prisoners of War and Detained Individuals in (b)(2)-2 and (b)(2)-2 to (b)(2)-2 OPORD 03-036 - 8 July 03

(S (b)(2)-2 FRAGO 520 [Medical Support for Abu Ghurayb] to (b)(2)-2 OPORD 03-036 - 27 Jul 03

(S) MNC-I FRAGO 1206 (10DEC03 DTU) to (b)(2)-2 OPORD 03-036 - 11 Dec 03

(S) MNC-I FRAGO 494 (Security for Detainees While in Medical Treatment Facilities) to (b)(2)-2 OPORD 04-01 - 25 Mar 04

(S) (b)(2)-2 FRAGO 014 (Task Organization Change) (b)(2)-2 TACON over MP medical Personnel - 16 Oct 04

(S) MNC-I FRAGO 016 (Health and Sanitation Inspections in Support of MNC-I Detention Facilities) to MNC-I OPORD 04-01 TO be Published {TBP}) - 17 Apr 04

(S) MNC-I FRAGO 018 (Medical Record Documentation and Filing System for U.S. Detainee Operations in Iraq AO) to MNC-I OPORD 04-01 (TBP) - 17 May 04

(S) MNC-I FRAGO 260 (Investigating and Reporting Detainee Deaths) to MNC-I OPORD 04-01 - 29 Jun 04

(S) MNC-I FRAGO 329 (Detention Operations) to MNC-IOPORD 04-01 - 12 Jul 04

(S) MNC-I FRAGO 955 (b)(2)-2 to Move Medical Equipment Sets to Bucca ISO (b)(2)-2 to MNC-I OPORD 04-01 - 3 Nov 04

(S) MNC-I FRAGO 1029 (Attach 40 Bed Patient Hold Capability to (b)(2)-2 to MNC-I OPORD 04-01 -13 Nov 04

(S) MNC-I FRAGO 1043 (Detainee Acceptance) to MNC-I OPORD 04-01 - 15 Nov 04

(S) MNC-I FRAGO 1173 (Detention Operations) to MNC-I OPORD 04-01 - 2 Nov 04

(S) (b)(2)-2 FRAGO 330 [Medical Coverage for MND-CS] to (b)(2)-2 OPORD Final Thrust - 10 Aug 03

(S) (b)(2)-2 FRAGO 341 [Medical Coverage for The Abu Ghraib Prison] to (b)(2)-2 (b)(2)-2 OPORD Final Thrust - 14 Aug 03

(S) (b)(2)-2 FRAGO 468 [Medical Equipment to Abu Ghraib Prison] to OPORD Final Thrust - 9 Nov 03

(S) (b)(2)-2 OPLAN 04-02 (Iraqi Freedom) - 1 Mar 04

(S) (b)(2)-2 Annex EE [Baghdad Central Detention Facility (BCDF) to (b)(2)-2 BDE OPLAN 04-02 (Iraqi Freedom) - 1 Mar 04

(S)	(b)(2)-2 FRAGO 6 (Detainee Operations Guidance) to Operations Order 02-01 - 4 Jun 02
(S)	(b)(2)-2 FRAGO 274 (Detainee Handling, Movement, and Temporary Transfer Guidance) - 26 Feb 04
(b)(2)-2	Questioning and Interrogation Approaches SOP - 15 Jan 05
(S)	(b)(2)-2 Detainee Operations Standard Operating Procedures - 21 Jan 05
(S)	(b)(2)-2 Standard Operating Procedures for Detainee Medical Care - 8 Mar 05
(S)	CDR USSOUTHCOM EXORD for Detainee Movement Operation 45 - 25 Feb 05
(S)	(b)(2)-2 Behavioral Science Consultation Team Standard Operating Procedures - 11 Nov 02